and capital costs is deducted from the additional payment that would otherwise be payable for the cost reporting period. For purposes of calculating the offset, the costs and payments for services that are not subject to the hospital inpatient prospective payment system are excluded.

(h) *Limit on exception payments.* Total estimated payments under the exception process may not exceed 10 percent of the total estimated capital prospective payments (exclusive of hold-harmless payments for old capital) for the same fiscal year.

[59 FR 45399, Sept. 1, 1994, as amended at 62 FR 46031, Aug. 29. 1997]

§ 412.352 Budget neutrality adjustment.

For FY 1992 through FY 1995, HCFA will determine an adjustment to the hospital-specific rate and the Federal rate proportionately so that the estimated aggregate payments under this subpart for inpatient hospital capital costs each fiscal year will equal 90 percent of what HCFA estimates would have been paid for capital-related costs on a reasonable cost basis under § 413.130 of this chapter.

SPECIAL RULES FOR PUERTO RICO HOSPITALS

§ 412.370 General provisions for hospitals located in Puerto Rico.

Except as provided in § 412.374, hospitals located in Puerto Rico are subject to the rules in this subpart governing the prospective payment system for inpatient hospital capital-related costs.

§ 412.374 Payments to hospitals located in Puerto Rico.

(a) Payments for capital-related costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of the following:

(1) 50 percent of a Puerto Rico capital rate based on data from Puerto Rico hospitals only, which is determined in accordance with procedures for developing the Federal rate; and

(2) 50 percent of the Federal rate, as determined under § 412.308.

(b) Effective for fiscal year 1998, the Puerto Rico capital rate described in paragraph (a) of this section in effect on September 30, 1997, is reduced by 15.68 percent.

(c) For discharges occurring on or after October 1, 1997 through September 30, 2002, the Puerto Rico capital rate described in paragraph (a) of this section in effect on September 30, 1997 is further reduced by 2.1 percent.

[62 FR 46032, Aug. 29, 1997]

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

Subpart A—Introduction and General Rules

Sec.

Subpart B—Accounting Records and Reports

Subpart C—Limits on Cost Reimbursement

Subpart D—Apportionment

Subpart E—Payments to Providers

Subpart F—Specific Categories of Costs

Subpart G—Capital-Related Costs

Subpart H—Payment for End-Stage Renal Disease (ESRD) Services and Organ Procurement Costs

Subpart I—Prospectively Determined Payment Rates for Low-Volume Skilled Nursing Facilities, for Cost Reporting Periods Beginning Prior to July 1, 1998

Subpart J—Prospective Payment for Skilled Nursing Facilities

AUTHORITY: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395g, 1395l, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww).

SOURCE: 51 FR 34793, Sept. 30, 1986, unless otherwise noted.

Subpart A—Introduction and General Rules

§ 413.1 Introduction.

(a) *Basis, scope, and applicability*—(1) *Statutory basis*—(i) *Basic provisions.* (A) Section 1815 of the Act requires that the Secretary make interim payments to providers and periodically determine the amount that should be paid under Part A of Medicare to each provider for the services it furnishes.

(B) Section 1814(b) of the Act (for Part A) and section 1833(a) (for Part B) provide for payment on the basis of the lesser of a provider's reasonable costs or customary charges.

(C) Section 1861(v) of the Act defines ''reasonable cost''.

(ii) *Additional provisions.* (A) Section 1138(b) of the Act specifies the conditions for Medicare payment for organ procurement costs.

(B) Section 1814(j) of the Act provides for exceptions to the ''lower of costs or charges'' provisions.

(C) Sections 1815(a) and 1833(e) of the Act provide the Secretary with authority to request information from providers to determine the amount of Medicare payment due providers.

(D) Section 1833(a)(4) and (i)(3) of the Act provide for payment of a blended amount for certain surgical services furnished in a hospital's outpatient department.

(E) Section 1833(n) of the Act provides for payment of a blended amount for outpatient hospital diagnostic procedures such as radiology.

(F) Section 1834(c)(1)(C) of the Act establishes the method for determining Medicare payment for screening mammograms performed by hospitals.

(G) Section 1834(g) of the Act provides that payment for critical access hospital (CAH) outpatient services is the reasonable costs of the CAH in providing these services, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in this part and in part 415 of this chapter.

(H) Section 1881 of the Act authorizes payment for services furnished to ESRD patients.

(I) Section 1883 of the Act provides for payment for post-hospital SNF care furnished by a rural hospital that has swing-bed approval.

(J) Sections 1886(a) and (b) of the Act impose a ceiling on the rate of increase in hospital inpatient costs.

(K) Section 1886(h) of the Act provides for payment to a hospital for the services of interns and residents in approved teaching programs on the basis of a ''per resident'' amount.

(2) *Scope.* This part sets forth regulations governing Medicare payment for services furnished to beneficiaries by—

(i) Hospitals and critical access hospitals (CAHs);

(ii) Skilled nursing facilities (SNFs);

(iii) Home health agencies (HHAs);

(iv) Comprehensive outpatient rehabilitation facilities (CORFs);

(v) End-stage renal disease (ESRD) facilities;

(vi) Providers of outpatient physical therapy and speech pathology services (OPTs); and

(vii) Organ procurement agencies (OPAs) and histocompatibility laboratories.

(viii) Community mental health centers (CMHCs) but only for purposes of furnishing partial hospitalization services.

(3) *Applicability.* The payment principles and related policies set forth in this part are binding on HCFA and its fiscal intermediaries, on the Provider Reimbursement Review Board, and on the entities listed in paragraph (a)(2) of this section.

(b) *Reasonable cost reimbursement.* Except as provided under paragraphs (c) through (f) of this section, Medicare is generally required, under section 1814(b) of the Act (for services covered under Part A) and under section 1833(a)(2) of the Act (for services covered under Part B) to pay for services furnished by providers on the basis of

reasonable costs as defined in section 1861(v) of the Act, or the provider's customary charges for those services, if lower. Regulations implementing section 1861(v) are found generally in this part beginning at §413.5.

(c) *Outpatient maintenance dialysis and related services.* Section 1881 of the Act authorizes special rules for the coverage of and payment for services furnished to ESRD patients. Sections 413.170 and 413.174 implement various provisions of section 1881. In particular, §413.170 establishes a prospective payment method for outpatient maintenance dialysis services that applies both to hospital-based and independent ESRD facilities, and under which Medicare pays for both home and infacility dialysis services furnished on or after August 1, 1983.

(d) *Payment for inpatient hospital services.* (1) For cost reporting periods beginning before October 1, 1983, the amount paid for inpatient hospital services is determined on a reasonable cost basis.

(2) Payment to short-term general hospitals located in the 50 States and the District of Columbia for the operating costs of hospital inpatient services for cost reporting periods beginning on or after October 1, 1983, and for the capital-related costs of inpatient services for cost reporting periods beginning on or after October 1, 1991, are determined prospectively on a per discharge basis under part 412 of this chapter except as follows:

(i) Payment for capital-related costs for cost reporting periods beginning before October 1, 1991, medical education costs, kidney acquisition costs, and the costs of certain anesthesia services, is described in §412.113 of this chapter.

(ii) Payment to children's, psychiatric, rehabilitation and long-term hospitals (as well as separate psychiatric and rehabilitation units (distinct parts) of short-term general hospitals), which are excluded from the prospective payment system under subpart B of part 412 of this chapter, and to hospitals outside the 50 States and the District of Columbia is on a reasonable cost basis, subject to the provisions of §413.40.

(iii) Payment to hospitals subject to a State reimbursement control system is described in paragraph (e) of this section.

(e) *State reimbursement control systems.* Beginning October 1, 1983, Medicare reimbursement for inpatient hospital services may be made in accordance with a State reimbursement control system rather than under the Medicare reimbursement principles set forth in this part, if the State system is approved by HCFA. Regulations implementing this alternative reimbursement authority are set forth in subpart C of part 403 of this chapter.

(f) *Services of qualified nonphysician anesthetists.* For cost reporting periods, or any part of a cost reporting period, beginning on or after January 1, 1989, costs incurred for the services of qualified nonphysician anesthetists are not paid on a reasonable cost basis unless the provisions of §412.113(c)(2) of this chapter apply. These services are paid under the special rules set forth in §405.553 of this chapter.

(g) *Payment for services furnished in SNFs.* (1) Except as specified in paragraph (g)(2)(ii) of this section, the amount paid for services furnished in cost reporting periods beginning before July 1, 1998, is determined on a reasonable cost basis or, where applicable, in accordance with the prospectively determined payment rates for low-volume SNFs established under section 1888(d) of the Act, as set forth in subpart I of this part.

(2) The amount paid for services (other than those described in §411.15(p)(2) of this chapter)—

(i) That are furnished in cost reporting periods beginning on or after July 1, 1998, to a resident who is in a covered Part A stay, is determined in accordance with the prospectively determined payment rates for SNFs established under section 1888(e) of the Act, as set forth in subpart J of this part.

(ii) That are furnished on or after July 1, 1998, to a resident who is not in a covered Part A stay, is determined in accordance with any applicable Part B fee schedule or, for a particular item or service to which no fee schedule applies, by using the existing payment

methodology utilized under Part B for such item or service.

[51 FR 34793, Sept. 30, 1986, as amended at 57 FR 33898, July 31, 1992; 57 FR 39829, Sept. 1, 1992; 58 FR 30670, May 26, 1993; 59 FR 6578, Feb. 11, 1994; 60 FR 33136, June 27, 1995; 60 FR 37594, July 21, 1995; 60 FR 50441, Sept. 29, 1995; 62 FR 31, Jan. 2, 1997; 62 FR 46032, 46037, Aug. 29, 1997; 63 FR 26309, May 12, 1998]

§ 413.5 Cost reimbursement: General.

(a) In formulating methods for making fair and equitable reimbursement for services rendered beneficiaries of the program, payment is to be made on the basis of current costs of the individual provider, rather than costs of a past period or a fixed negotiated rate. All necessary and proper expenses of an institution in the production of services, including normal standby costs, are recognized. Furthermore, the share of the total institutional cost that is borne by the program is related to the care furnished beneficiaries so that no part of their cost would need to be borne by other patients. Conversely, costs attributable to other patients of the institution are not to be borne by the program. Thus, the application of this approach, with appropriate accounting support, will result in meeting actual costs of services to beneficiaries as such costs vary from institution to institution. However, payments to providers of services for services furnished Medicare beneficiaries are subject to the provisions of §§ 413.13 and 413.30.

(b) Putting these several points together, certain tests have been evolved for the principles of reimbursement and certain goals have been established that they should be designed to accomplish. In general terms, these are the tests or objectives:

(1) That the methods of reimbursement should result in current payment so that institutions will not be disadvantaged, as they sometimes are under other arrangements, by having to put up money for the purchase of goods and services well before they receive reimbursement.

(2) That, in addition to current payment, there should be retroactive adjustment so that increases in costs are taken fully into account as they actually occurred, not just prospectively.

(3) That there be a division of the allowable costs between the beneficiaries of this program and the other patients of the provider that takes account of the actual use of services by the beneficiaries of this program and that is fair to each provider individually.

(4) That there be sufficient flexibility in the methods of reimbursement to be used, particularly at the beginning of the program, to take account of the great differences in the present state of development of recordkeeping.

(5) That the principles should result in the equitable treatment of both nonprofit organizations and profit-making organizations.

(6) That there should be a recognition of the need of hospitals and other providers to keep pace with growing needs and to make improvements.

(c) As formulated herein, the principles given recognition to such factors as depreciation, interest, bad debts, educational costs, compensation of owners, and an allowance for a reasonable return on equity capital (in the case of certain proprietary providers). With respect to allowable costs some items of inclusion and exclusion are:

(1) An appropriate part of the net cost of approved educational activities will be included.

(2) Costs incurred for research purposes, over and above usual patient care, will not be included.

(3) [Reserved]

(4) The value of services provided by nonpaid workers, as members of an organization (including services of members of religious orders) having an agreement with the provider to furnish such services, is includable in the amount that would be paid others for similar work.

(5) Discounts and allowances received on the purchase of goods or services are reductions of the cost to which they relate.

(6) Bad debts growing out of the failure of a beneficiary to pay the deductible, or the coinsurance, will be reimbursed (after bona fide efforts at collection).

(7) Charity and courtesy allowances are not includable, although ''fringe benefit'' allowances for employees under a formal plan will be includable as part of their compensation.

(8) A reasonable allowance of compensation for the services of owners in profitmaking organizations will be allowed providing their services are actually performed in a necessary function.

(9) Reasonable cost of physicians' direct medical and surgical services (including supervision of interns and residents in the care of individual patients) furnished in a teaching hospital may be reimbursed as a provider cost (as described in §415.162 of this chapter) if elected as provided for in §415.160 of this chapter.

(d) In developing these principles of reimbursement for the Medicare program, all of the considerations inherent in allowances for depreciation were studied. The principles, as presented, provide options to meet varied situations. Depreciation will essentially be on an historical cost basis but since many institutions do not have adequate records of old assets, the principles provide an optional allowance in lieu of such depreciation for assets acquired before 1966. For assets acquired after 1965, the historical cost basis must be used. All assets actually in use for production of services for Medicare beneficiaries will be recognized even though they may have been fully or partially depreciated for other purposes. Assets financed with public funds may be depreciated. Although funding of depreciation is not required, there is an incentive for it since income from funded depreciation is not considered as an offset which must be taken to reduce the interest expense that is allowable as a program cost.

(e) A return on the equity capital of proprietary facilities, as described in §413.157, is an allowance in addition to the reasonable cost of covered services furnished to beneficiaries.

(f) Renal dialysis items and services furnished under the ESRD provision are reimbursed and reported under §§413.170 and 413.174 respectively. For special rules concerning health maintenance organizations (HMOs), and providers of services and other health care facilities that are owned or operated by an HMO, or related to an HMO by common ownership or control, see §§417.242(b)(14) and 417.250(c) of this chapter.

[51 FR 34793, Sept. 30, 1986; 51 FR 37398, Oct. 22, 1986, as amended at 52 FR 21225, June 4, 1987; 52 FR 23398, June 19, 1987; 57 FR 39829, Sept. 1, 1992; 60 FR 63189, Dec. 8, 1995; 61 FR 63748, Dec. 2, 1996]

§413.9 Cost related to patient care.

(a) *Principle.* All payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in furnishing the services, subject to principles relating to specific items of revenue and cost. However, for cost reporting periods beginning after December 31, 1973, payments to providers of services are based on the lesser of the reasonable cost of services covered under Medicare and furnished to program beneficiaries or the customary charges to the general public for such services, as provided for in §413.13.

(b) *Definitions*—(1) *Reasonable cost.* Reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included. The regulations in this part take into account both direct and indirect costs of providers of services. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program. These regulations also provide for the making of suitable retroactive adjustments after the provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the provider during the year for covered services from both Medicare and the beneficiaries and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of services furnished to beneficiaries during the year.

(2) *Necessary and proper costs.* Necessary and proper costs are costs that are appropriate and helpful in developing and maintaining the operation of

patient care facilities and activities. They are usually costs that are common and accepted occurrences in the field of the provider's activity.

(c) *Application.* (1) It is the intent of Medicare that payments to providers of services should be fair to the providers, to the contributors to the Medicare trust funds, and to other patients.

(2) The costs of providers' services vary from one provider to another and the variations generally reflect differences in scope of services and intensity of care. The provision in Medicare for payment of reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another. This is subject to a limitation if a particular institution's costs are found to be substantially out of line with other institutions in the same area that are similar in size, scope of services, utilization, and other relevant factors.

(3) The determination of reasonable cost of services must be based on cost related to the care of Medicare beneficiaries. Reasonable cost includes all necessary and proper expenses incurred in furnishing services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. It includes both direct and indirect costs and normal standby costs. However, if the provider's operating costs include amounts not related to patient care, specifically not reimbursable under the program, or flowing from the provision of luxury items or services (that is, those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts will not be allowable. The reasonable cost basis of reimbursement contemplates that the providers of services would be reimbursed the actual costs of providing quality care however widely the actual costs may vary from provider to provider and from time to time for the same provider.

[51 FR 34795, Sept. 30, 1986; 51 FR 37398, Oct. 22, 1986]

§ 413.13 Amount of payment if customary charges for services furnished are less than reasonable costs.

(a) *Definitions.* As used in this section—

Fair compensation means, for the purpose of providers that meet the nominal charge provisions in paragraph (f) of this section, the reasonable cost of covered services furnished to beneficiaries.

New provider means a provider that has operated as the type of facility for which it has been approved for participation in the Medicare program (for example, as a SNF or an HHA) under present and previous ownership for less than three full years.

Provider with a significant portion of low-income patients means a nonpublic provider whose charges are 60 percent or less of the reasonable cost represented by the charges, and that demonstrates, as required under paragraph (c)(1)(iii) of this section, that its charges are less than costs because its customary practice is to charge patients based on their ability to pay.

Public provider means a provider operated by a Federal, State, county, city, or other local government agency or instrumentality.

(b) *Application of the principle of lesser of costs or charges*—(1) *General rule.* Except as provided in paragraph (c) of this section, effective with cost reporting periods beginning on or after January 1, 1974, hospitals, SNFs, HHAs, OPTs, and CMHCs but only for purposes of providing partial hospitalization services, are paid the lesser of the reasonable cost (as described in paragaraph (d) of this section) of covered services furnished to beneficiaries or the customary charges (as defined in paragraph (e) of this section) made by the provider for the same services. The carryover of unreimbursed reasonable costs from previous cost reporting periods is recognized, in accordance with the provisions of paragraph (h) of this section.

(2) *Example.* A provider's reasonable cost for covered services furnished to Medicare beneficiaries during a cost reporting period is $125,000. The customary charges to those beneficiaries

for these services is $110,000. The provider is to be reimbursed $110,000 less deductible and coinsurance amounts that the beneficiaries are charged.

(c) *Providers and services not subject to the principle*—(1) *Providers*—(i) *CORFs.* Payment to CORFs is based on the reasonable cost of the services.

(ii) *Public providers.* Public providers furnishing services free of charge or at a nominal charge (as specified in paragraph (f) of this section) are paid fair compensation for services furnished to beneficiaries.

(iii) *Providers furnishing services to a significant portion of low-income patients.* Effective with cost reporting periods beginning on or after October 1, 1984, a provider furnishing services at a nominal charge (as specified in paragraph (f) of this section) is paid fair compensation, upon request, for services furnished to beneficiaries if the provider can demonstrate to its intermediary that a significant portion of its patients are low income and that its charges are less than costs because its customary practice is to charge patients based on their ability to pay.

(2) *Services*—(i) *Part A inpatient hospital services.* The lesser of costs or charges principle does not apply to Part A inpatient hospital services subject to—

(A) The rate-of-increase limits under §413.40, effective with cost reporting periods beginning on or after October 1, 1982; or

(B) The prospective payment system under Part 412 of this chapter, effective with cost reporting periods beginning on or after October 1, 1983.

(ii) *Special rule for facility services related to ambulatory surgical procedures performed in outpatient hospital departments.* Effective for hospitals with cost reporting periods beginning on or after October 1, 1987, reasonable costs and customary charges for those services relating to ambulatory surgical procedures that are subject to the payment methodology described in §413.118 are aggregated and treated separately from all other hospital costs and charges incurred during the cost reporting period.

(iii) *Durable medical equipment furnished by HHAs*—(A) *General.* Except as provided in paragraph (c)(2)(iii)(B) of this section, for durable medical equipment furnished by an HHA as a home health service on or after July 18, 1984, the HHA is paid the lesser of the reasonable cost of the equipment or the customary charges (less a 20 percent coinsurance as provided in section 1866(a)(2)(A)(ii) of the Act), not to exceed 80 percent of the reasonable cost of the equipment. The lesser of cost or charges determination for durable medical equipment is made separately from all other items or services furnished in an HHA regardless of whether the equipment is furnished under Part A or Part B.

(B) *HHAs meeting the nominal charge provisions.* A public HHA, or an HHA that demonstrates that a significant portion of its patients are low-income patients under the nominal charge provisions, as provided in paragraph (f)(2) of this section, are paid 80 percent of fair compensation for durable medical equipment furnished as a home health service on or after July 18, 1984.

(iv) *Critical access hospital (CAH) services.* The lesser of costs or charges principle does not apply in determining payment for inpatient or outpatient services furnished by a CAH under §413.70.

(3) *Hospital outpatient radiology services.* The reasonable costs and customary charges for hospital outpatient radiology services furnished on or after October 1, 1988, that are subject to the payment method described in §413.122, are aggregated and treated separately from all other hospital costs and charges incurred during the cost reporting period.

(4) *Other diagnostic procedures performed by a hospital on an outpatient basis.* The reasonable costs and customary charges for other diagnostic procedures identified by HCFA, that are performed on an outpatient basis by a hospital on or after October 1, 1989, and that are subject to the payment method described in §413.122, are aggregated and treated separately from all other hospital costs or charges incurred during the cost reporting period.

(d) *Exclusions from reasonable cost.* For purposes of comparison with customary charges under this section, reasonable cost does not include—

(1) Payments made to a provider as reimbursement for bad debts arising from noncollection of Medicare deductible and coinsurance amounts (§ 413.80);

(2) Amounts that represent the recovery of excess depreciation resulting from termination in the Medicare program or a decrease in Medicare utilization (§ 413.134(d)(3)) applicable to prior cost reporting periods;

(3) Amounts that result from a disposition of depreciable assets (§ 413.134(f)), applicable to prior cost reporting periods;

(4) Payments to funds for the donated services of teaching physicians (§ 413.85); and

(5) Graduate medical education costs for cost reporting periods beginning on or after July 1, 1985.

(e) *Customary charges*—(1) *General.* As used in this paragraph (e), customary charges means the charges for services, as defined in § 413.53(b), furnished to beneficiaries. These charges must be recorded on all bills submitted for program reimbursement.

(2) *Special situations in which customary charges are reduced.* Customary charges are reduced in proportion to the ratio of the aggregate amount actually collected from charge-paying non-Medicare patients to the amount that would have been realized had customary charges been paid and the provider—

(i) Did not actually impose charges in the case of most patients liable for payment for its services on a charge basis; or

(ii) Failed to make a reasonable effort to collect those charges.

(f) *Nominal charges*—(1) *Cost reporting periods beginning before October 1, 1984.* Except for durable medical equipment furnished by HHAs as provided in paragraph (c)(2)(iii) of this section, if a public provider's total charges, for cost reporting periods beginning before October 1, 1984, are less than one-half of the reasonable cost of services or items represented by these charges, then the provider is reimbursed fair compensation.

(2) *Cost reporting periods beginning on or after October 1, 1984.* For cost reporting periods beginning on or after October 1, 1984, the following provisions apply in determining nominal charges:

(i) *Reimbursement of fair compensation.* Except for the limitations on reimbursement for durable medical equipment furnished by HHAs as provided in paragraph (c)(2)(iii) of this section, public providers, and providers with a significant portion of low-income patients that request payment under this paragraph are reimbursed fair compensation if total charges are 60 percent or less of the reasonable cost of services or items represented by these charges.

(ii) *Separate determination of nominal charges.* Except as provided in paragraph (f)(2)(iii) of this section, the determination of nominal charges, which is based on charges actually billed to charge-paying, non-Medicare patients, is made separately with respect to inpatient and outpatient services (other than clinical diagnostic laboratory tests that are paid under section 1833(h) of the Act).

(iii) *Determination of nominal charges in special situations.* (A) For providers that have a sliding scale or discounted schedule of charges based on patients' ability to pay, the determination of nominal charges is based on charges billed to all charge-paying patients. This determination is made using the ratio of sliding scale or discounted charges to the provider's full customary charges. For determining nominal charges, the ratio is applied to the provider's Medicare charges to equate those charges to customary charges.

(B) For HHAs, the determination of nominal charges for all items and services other than durable medical equipment is made on an aggregate basis. The nominal charge determination for durable medical equipment is made separately from other items or services furnished by HHAs.

(C) For cost reporting periods beginning on or after July 1, 1985, graduate medical education payments (or a provider's graduate medical education reasonable costs if supported by appropriate data) are included in reasonable costs when making the nominal charge determination.

(g) *The aggregation method*—(1) *Cost reporting periods beginning before October 1, 1984—Application.* In comparing costs and charges under the lesser of costs or

charges principle for cost reporting periods beginning before October 1, 1984, the reasonable cost for items and services and the customary charges for those same items and services are to be aggregated (that is, totalled and compared) without regard to whether the services are reimbursable under Part A or Part B of Medicare. This aggregation method is to be applied after the provider's charges and costs have been adjusted to exclude the amounts described in paragraph (d) of this section and to exclude—

(i) Any amounts attributable to physician services not reimbursable to the provider on a reasonable cost basis as described in §§415.55 through 415.70 of this chapter; and

(ii) All costs and charges for noncovered provider services.

(2) *Cost reporting periods beginning on or after October 1, 1984.* Effective with cost reporting periods beginning on or after October 1, 1984, the aggregation method used for computing the lesser of costs or charges, as set forth in paragraph (g)(1) of this section, may not be used. For covered items and services furnished during these periods, total reasonable cost of covered items and services is compared with total customary charges for those items and services, separately for Part A and for Part B.

(h) *Accumulation of unreimbursed costs and carryover to subsequent periods*—(1) *General rule.* A provider whose charges are lower than its reasonable cost for those services in any cost reporting period beginning on or after January 1, 1974 but before April 28, 1988, may carry forward costs that are unreimbursed under paragraph (b) of this section for the two succeeding cost reporting periods. However, no recovery may be made in any period in which costs are unreimbursed because a provider's costs exceed the limitations on reimbursable costs (§413.30) or the ceiling on the rate of hospital cost increases (§413.40).

(2) *Reimbursement as a result of carryover.* The provider is reimbursed for the costs that are carried forward to a succeeding cost reporting period—

(i) If total charges for services provided in that subsequent period exceed the total reasonable cost of the services; and

(ii) To the extent that accumulation of the costs being carried forward and the costs for the services provided in that subsequent period do not exceed the customary charges for those services.

(3) *Two succeeding periods less than 24 months.* If the two succeeding cost reporting periods are less than 24 full calendar months, the provider may carry forward the unreimbursed costs for one additional cost reporting period.

(4) *Example.* In the cost reporting period ending September 30, 1982, a provider's reasonable costs were $100,000. The provider's customary charges for those services were $90,000. The provider is reimbursed $90,000 less any deductible and coinsurance amounts but is permitted to carry forward the unreimbursed reasonable costs of $10,000 for the next two succeeding cost reporting periods. If, in the cost reporting period ending September 30, 1983, customary charges to beneficiaries exceeded the reasonable costs for those services by $10,000 or more, and the provider had no costs unreimbursed under §413.30 or §413.40, the provider would recover the entire $10,000 previously not reimbursed. If, however, beneficiary charges for that cost reporting period exceeded costs by only $8,000, this amount ($8,000) would be added to the provider's reimbursable costs for this period. The balance of the unreimbursed amount ($2,000) would be carried forward to the next cost reporting period.

(5) *New providers.* (i) *General rule.* A new provider whose cost reporting period begins before April 28, 1988, may carry forward costs that are unreimbursed from previous periods, as described in paragraph (b) of this section, during a provider's base period. The base period includes any cost reporting period beginning on or after January 1, 1974, and ending on or before the last day of its third year of operation. The unreimbursed costs may be carried forward for the five succeeding cost reporting periods. However, no recovery may be made in any period in which costs are unreimbursed because a provider's costs exceed the limitations on

reimbursable costs (§ 413.30) or the ceiling on the rate of hospital cost increases (§ 413.40).

(ii) *Reimbursement as a result of carryover.* The new provider is reimbursed for the costs that are carried forward to a succeeding cost reporting period—

(A) If total charges for the services provided in that subsequent period exceed the total reasonable cost of the services; and

(B) To the extent that accumulation of the costs being carried forward and the costs for the services provided in that subsequent period do not exceed the customary charges for those services.

(iii) *Five succeeding periods less than 60 months.* If the five succeeding cost reporting periods are less than 60 full calendar months, the provider may carry forward the unreimbursed costs for one additional cost reporting period.

(iv) *Example.* A provider begins its operations on March 5, 1972. However, it begins to participate in the Medicare program as of January 1, 1973, and reports on a calendar year basis. Because the provider would be subject to the lesser of cost or charges principle for its cost reporting period beginning with January 1, 1974, it would be permitted to accumulate any unreimbursed costs (excess of costs over its charges) incurred during this reporting period. Therefore, because this cost reporting period ends before the end of the third year of operation, its carryover period would be the succeeding five cost reporting periods ending with December 31, 1979. If this provider had begun its operation on July 1, 1973, and become a participating provider as of the same date (with a fiscal year ending June 30), it would have been able to accumulate any unreimbursed costs for the two cost reporting periods ending June 30, 1975, and June 30, 1976. Its carryover period would then be the five cost reporting periods ending no later than June 30, 1981, in the case of costs unreimbursed in either of the reporting periods ending June 30, 1975, or June 30, 1976.

[53 FR 10085, Mar. 29, 1988; 53 FR 12641, Apr. 15, 1988, as amended at 54 FR 40315, Sept. 29, 1989; 56 FR 8842, Mar. 1, 1991; 58 FR 30670, May 26, 1993; 59 FR 6578, Feb. 11, 1994; 60 FR 63189, Dec. 8, 1995; 62 FR 46032, Aug. 29, 1997; 63 FR 26357, May 12, 1998]

§ 413.17 Cost to related organizations.

(a) *Principle.* Except as provided in paragraph (d) of this section, costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

(b) *Definitions.* (1) *Related to the provider.* Related to the provider means that the provider to a significant extent is associated or affiliated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(2) *Common ownership.* Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.

(3) *Control.* Control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

(c) *Application.* (1) Individuals and organizations associate with others for various reasons and by various means. Some deem it appropriate to do so to assure a steady flow of supplies or services, to reduce competition, to gain a tax advantage, to extend influence, and for other reasons. These goals may be accomplished by means of ownership or control, by financial assistance, by management assistance, and other ways.

(2) If the provider obtains items of services, facilities, or supplies from an

organization, even though it is a separate legal entity, and the organization is owned or controlled by the owner(s) of the provider, in effect the items are obtained from itself. An example would be a corporation building a hospital or a nursing home and then leasing it to another corporation controlled by the owner. Therefore, reimbursable cost should include the costs for these items at the cost to the supplying organization. However, if the price in the open market for comparable services, facilities, or supplies is lower than the cost to the supplier, the allowable cost to the provider may not exceed the market price.

(d) *Exception.* (1) An exception is provided to this general principle if the provider demonstrates by convincing evidence to the satisfaction of the fiscal intermediary (or, if the provider has not nominated a fiscal intermediary, HCFA), that—

(i) The supplying organization is a bona fide separate organization;

(ii) A substantial part of its business activity of the type carried on with the provider is transacted with others than the provider and organizations related to the supplier by common ownership or control and there is an open, competitive market for the type of services, facilities, or supplies furnished by the organization;

(iii) The services, facilities, or supplies are those that commonly are obtained by institutions such as the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions; and

(iv) The charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

(2) In such cases, the charge by the supplier to the provider for such services, facilities, or supplies is allowable as cost.

Subpart B—Accounting Records and Reports

§ 413.20 Financial data and reports.

(a) *General.* The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement. Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basis accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries.

(b) *Frequency of cost reports.* Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. In the interpretation and application of the principles of reimbursement, the fiscal intermediaries will be an important source of consultative assistance to providers and will be available to deal with questions and problems on a day-to-day basis.

(c) *Recordkeeping requirements for new providers.* A newly participating provider of services (as defined in § 400.202 of this chapter) must make available to its selected intermediary for examination its fiscal and other records for the purpose of determining such provider's ongoing recordkeeping capability and inform the intermediary of the date its initial Medicare cost reporting period ends. This examination is intended to assure that—

(1) The provider has an adequate ongoing system for furnishing the records needed to provide accurate cost data and other information capable of verification by qualified auditors and adequate for cost reporting purposes under section 1815 of the Act; and

(2) No financial arrangements exist that will thwart the commitment of the Medicare program to reimburse providers the reasonable cost of services furnished beneficiaries. The data and information to be examined include cost, revenue, statistical, and other information pertinent to reimbursement including, but not limited to, that described in paragraph (d) of this section and in § 413.24.

(d) *Continuing provider recordkeeping requirements.* (1) The provider must furnish such information to the intermediary as may be necessary to—

(i) Assure proper payment by the program, including the extent to which there is any common ownership or control (as described in § 413.17(b)(2) and (3)) between providers or other organizations, and as may be needed to identify the parties responsible for submitting program cost reports;

(ii) Receive program payments; and

(iii) Satisfy program overpayment determinations.

(2) The provider must permit the intermediary to examine such records and documents as are necessary to ascertain information pertinent to the determination of the proper amount of program payments due. These records include, but are not limited to, matters pertaining to—

(i) Provider ownership, organization, and operation;

(ii) Fiscal, medical, and other recordkeeping systems;

(iii) Federal income tax status;

(iv) Asset acquisition, lease, sale, or other action;

(v) Franchise or management arrangements;

(vi) Patient service charge schedules;

(vii) Costs of operation;

(viii) Amounts of income received by source and purpose; and

(ix) Flow of funds and working capital.

(3) The provider, upon request, must furnish the intermediary copies of patient service charge schedules and changes thereto as they are put into effect. The intermediary will evaluate such charge schedules to determine the extent to which they may be used for determining program payment.

(e) *Suspension of program payments to a provider.* If an intermediary determines that a provider does not maintain or no longer maintains adequate records for the determination of reasonable cost under the Medicare program, payments to such provider will be suspended until the intermediary is assured that adequate records are maintained. Before suspending payments to a provider, the intermediary will, in accordance with the provisions in § 405.372(a) of this chapter, send written notice to such provider of its intent to suspend payments. The notice will explain the basis for the intermediary's determination with respect to the provider's records and will identify the provider's recordkeeping deficiencies. The provider must be given the opportunity, in accordance with § 405.372(b) of this chapter, to submit a statement (including any pertinent evidence) as to why the suspension must not be put into effect.

[51 FR 34793, Sept. 30, 1986, as amended at 61 FR 63749, Dec. 2, 1996]

§ 413.24 Adequate cost data and cost finding.

(a) *Principle.* Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting.

However, if governmental institutions operate on a cash basis of accounting, cost data based on such basis of accounting will be acceptable, subject to appropriate treatment of capital expenditures.

(b) *Definitions.* (1) *Cost finding.* Cost finding is the process of recasting the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services furnished. It is the determination of these costs by the allocation of direct costs and proration of indirect costs.

(2) *Accrual basis of accounting.* As used in this part, the term *accrual basis of accounting* means that revenue is reported in the period in which it is earned, regardless of when it is collected; and an expense is reported in the period in which it is incurred, regardless of when it is paid. (See § 413.100

regarding limitations on allowable accrued costs in situations in which the related liabilities are not liquidated timely.)

(c) *Adequacy of cost information.* Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended. Adequate data capable of being audited is consistent with good business concepts and effective and efficient management of any organization, whether it is operated for profit or on a nonprofit basis. It is a reasonable expectation on the part of any agency paying for services on a cost-reimbursement basis. In order to provide the required cost data and not impair comparability, financial and statistical records should be maintained in a manner consistent from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures if there is reason to effect such change.

(d) *Cost finding methods.* After the close of the accounting period, providers must use one of the following methods of cost finding to determine the actual costs of services furnished during that period. (These provisions do not apply to SNFs that elect and qualify for prospectively determined payment rates under subpart I of this part for cost reporting periods beginning on or after October 1, 1986. For the special rules that are applicable to those SNFs, see §413.321.) For cost reporting periods beginning after December 31, 1971, providers using the departmental method of cost apportionment must use the step-down method described in paragraph (d)(1) of this section or an ''other method'' described in paragraph (d)(2) of this section. For cost reporting periods beginning after December 31, 1971, providers using the combination method of cost apportionment must use the modified cost finding method described in paragraph (d)(3) of this section. Effective for cost reporting periods beginning on or after October 1, 1980, HHAs not based in hospitals or SNFs must use the step-down method described in paragraph (d)(1) of this section. (HHAs based in hospitals or SNFs must use the method applicable to the parent institution.) However, an HHA not based in a hospital or SNF that received less than $35,000 in Medicare payment for the immediately preceding cost reporting period, and for whom this payment represented less than 50 percent of the total operating cost of the agency, may use a simplified version of the step-down method, as specified in instructions for the cost report issued by HCFA.

(1) *Step-down Method.* This method recognizes that services furnished by certain nonrevenue-producing departments or centers are utilized by certain other nonrevenue-producing centers as well as by the revenue-producing centers. All costs of nonrevenue-producing centers are allocated to all centers that they serve, regardless of whether or not these centers produce revenue. The cost of the nonrevenue-producing center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. Following the apportionment of the cost of the nonrevenue-producing center, that center will be considered ''closed'' and no further costs are apportioned to that center. This applies even though it may have received some service from a center whose cost is apportioned later. Generally, if two centers furnish services to an equal number of centers while receiving benefits from an equal number, that center which has the greatest amount of expense should be allocated first.

(2) *Other methods.* (i) *The double-apportionment method.* The double-apportionment method may be used by a provider upon approval of the intermediary. This method also recognizes that the nonrevenue-producing departments or centers furnish services to other nonrevenue-producing centers as well as to revenue-producing centers. A preliminary allocation of the costs of non-revenue-producing centers is made. These centers or departments are not ''closed'' after this preliminary allocation. Instead, they remain ''open,'' accumulating a portion of the costs of all other centers from which services are received. Thus, after the

first or preliminary allocation, some costs will remain in each center representing services received from other centers. The first or preliminary allocation is followed by a second or final apportionment of expenses involving the allocation of all costs remaining in the nonrevenue-producing functions directly to revenue-producing centers.

(ii) *More sophisticated methods.* A more sophisticated method designed to allocate costs more accurately may be used by the provider upon approval of the intermediary. However, having elected to use the double-apportionment method, the provider may not thereafter use the step-down method without approval of the intermediary. Written request for the approval must be made on a prospective basis and must be submitted before the end of the fourth month of the prospective reporting period. Likewise, once having elected to use a more sophisticated method, the provider may not thereafter use either the double-apportionment or step-down methods without similar request and approval.

(3) *Modified cost finding for providers using the Combination Method for reporting periods beginning after December 31, 1971.* This method differs from the step-down method in that services furnished by nonrevenue-producing departments or centers are allocated directly to revenue-producing departments or centers even though these services may be utilized by other nonrevenue-producing departments or centers. In the application of this method the cost of nonrevenue-producing centers having a common basis of allocation are combined and the total distributed to revenue-producing centers. All nonrevenue-producing centers having significant percentages of cost in relation to total costs will be allocated this way. The combined total costs of remaining nonrevenue-producing costs centers will be allocated to revenue-producing cost centers in the proportion that each bears to total costs, direct and indirect, already allocated. The bases which are to be used and the centers which are to be combined for allocation are not optional but are identified and incorporated in the cost report forms developed for this method. Providers using this method must use the program cost report forms devised for it. Alternative forms may not be used without prior approval by HCFA based upon a written request by the provider submitted through the intermediary.

(4) *Temporary method for initial period.* If the provider is unable to use either cost-finding method when it first participates in the program, it may apply to the intermediary for permission to use some other acceptable method that would accurately identify costs by department or center, and appropriately segregate inpatient and outpatient costs. Such other method may be used for cost reports covering periods ending before January 1, 1968.

(5) *Simplified optional reimbursement method for small, rural hospitals with distinct parts for cost reporting periods beginning on or after July 20, 1982.* (i) A rural hospital with a Medicare-certified distinct part SNF may elect to be reimbursed for services furnished in its hospital general routine service area and distinct part SNF using the reimbursement method specified in §413.53 for swing-bed hospitals, if it meets the following conditions:

(A) The institution is located in a rural area as defined in §482.66 of this chapter.

(B) On the first day of the cost reporting period, the hospital and distinct part SNF have fewer than 50 beds in total (with the exception of beds for newborns and beds in intensive care type inpatient units).

(ii) In applying the optional reimbursement method, only those beds located in the hospital general routine service area and in the distinct part SNF certified by Medicare are combined into a single cost center for purposes of cost finding.

(iii) The reasonable cost of the routine extended care services is determined in accordance with §413.114(c). The reasonable cost of the hospital general routine services is determined in accordance with §413.53(a)(2).

(iv) The hospital must make its election to use the optional swing-bed reimbursement method in writing to the intermediary before the beginning of the hospital's cost reporting year. The hospital must make any request to revoke the election in writing before the

beginning of the affected cost reporting period.

(v) The intermediary must approve requests to terminate use of the optional swing-bed reimbursement method. If a hospital terminates use of this optional method, no further elections may be made by the facility to use the optional method.

(e) *Accounting basis.* The cost data submitted must be based on the accrual basis of accounting which is recognized as the most accurate basis for determining costs. However, governmental institutions that operate on a cash basis of accounting may submit cost data on the cash basis subject to appropriate treatment of capital expenditures.

(f) *Cost reports.* For cost reporting purposes, the Medicare program requires each provider of services to submit periodic reports of its operations that generally cover a consecutive 12-month period of the provider's operations. Amended cost reports to revise cost report information that has been previously submitted by a provider may be permitted or required as determined by HCFA.

(1) *Cost reports—Terminated providers and changes of ownership.* A provider that voluntarily or involuntarily ceases to participate in the Medicare program or experiences a change of ownership must file a cost report for that period under the program beginning with the first day not included in a previous cost reporting period and ending with the effective date of termination of its provider agreement or change of ownership.

(2) *Due dates for cost reports.* (i) Cost reports are due on or before the last day of the fifth month following the close of the period covered by the report. For cost reports ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period.

(ii) Extensions of the due date for filing a cost report may be granted by the intermediary only when a provider's operations are significantly adversely affected due to extraordinary circumstances over which the provider has no control, such as flood or fire.

(3) *Changes in cost reporting periods.* A provider may change its cost reporting period if a change in ownership is experienced or if the—

(i) Provider requests the change in writing from its intermediary;

(ii) Intermediary receives the request at least 120 days before the close of the new reporting period requested by the provider; and

(iii) Intermediary determines that good cause for the change exists. Good cause would not be found to exist if the effect is to change the initial date that a hospital would be affected by the rate of increase ceiling (see § 413.40), or be paid under the prospective payment systems (see part 412 of this chapter).

(4) *Electronic submission of cost reports.* (i) As used in this paragraph, ''provider'' means a hospital, skilled nursing facility, or home health agency.

(ii) Effective for cost reporting periods beginning on or after October 1, 1989, for hospitals, and cost reporting periods ending on or after February 1, 1997, for skilled nursing facilities and home health agencies, a provider is required to submit cost reports in a standardized electronic format. The provider's electronic program must be capable of producing the HCFA standardized output file in a form that can be read by the fiscal intermediary's automated system. This electronic file, which must contain the input data required to complete the cost report and the data required to pass specified edits, is forwarded to the fiscal intermediary for processing through its system.

(iii) The fiscal intermediary stores the provider's as-filed electronic cost report and may not alter that file for any reason. The fiscal intermediary makes a ''working copy'' of the as-filed electronic cost report to be used, as necessary, throughout the settlement process (that is, desk review, processing audit adjustments, final settlement, etc). The provider's electronic program must be able to disclose if any changes have been made to the as-filed electronic cost report after acceptance by the intermediary. If the as-filed electronic cost report does not pass all specified edits, the fiscal intermediary rejects the cost report and returns it to the provider for correction. For purposes of the requirements in paragraph (f)(2) of this section concerning due

dates, an electronic cost report is not considered to be filed until it is accepted by the intermediary.

(iv) Effective for cost reporting periods ending on or after September 30, 1994, for hospitals, and cost reporting periods ending on or after, February 1, 1997, for skilled nursing facilities and home health agencies, a provider must submit a hard copy of a settlement summary, a statement of certain worksheet totals found within the electronic file, and a statement signed by its administrator or chief financial officer certifying the accuracy of the electronic file or the manually prepared cost report. During a transition period, skilled nursing facilities and home health agencies must submit a hard copy of the completed cost report forms in addition to the electronic file. The following statement must immediately precede the dated signature of the provider's administrator or chief financial officer:

I hereby certify that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet Statement of Revenue and Expenses prepared by _____ (Provider Name(s) and Number(s)) for the cost reporting period beginning _____ and ending _____ and that to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(v) A provider may request a delay or waiver of the electronic submission requirement in paragraph (f)(4)(ii) of this section if this requirement would cause a financial hardship or if the provider qualifies as a low or no Medicare utilization provider. The provider must submit a written request for delay or waiver with necessary supporting documentation to its intermediary no later than 30 days after the end of its cost reporting period. The intermediary reviews the request and forwards it, with a recommendation for approval or denial, to HCFA central office within 30 days of receipt of the request. HCFA central office either approves or denies the request and notifies the intermediary within 60 days of receipt of the request.

(5) An acceptable cost report submission is defined as follows:

(i) All providers—The provider, must complete and submit the required cost reporting forms, including all necessary signatures. A cost report is rejected for lack of supporting documentation only if it does not include the Provider Cost Reimbursement Questionnaire. Additionally, a cost report for a teaching hospital is rejected for lack of supporting documentation if the cost report does not include a copy of the Intern and Resident Information System diskette.

(ii) For providers that are required to file electronic cost reports—In addition to the requirements of paragraphs (f)(4) and (f)(5)(i) of this section, the provider must submit its cost reports in an electronic cost report format in conformance with the requirements contained in the Electronic Cost Report (ECR) Specifications Manual (unless the provider has received an exemption from HCFA).

(iii) The intermediary makes a determination of acceptability within 30 days of receipt of the provider's cost report. If the cost report is considered unacceptable, the intermediary returns the cost report with a letter explaining the reasons for the rejection. When the cost report is rejected, it is deemed an unacceptable submission and treated as if a report had never been filed.

(g) *Exception from full cost reporting for lack of program utilization.* If a provider does not furnish any covered services to Medicare beneficiaries during a cost reporting period, it is not required to submit a full cost report. It must, however, submit an abbreviated cost report, as prescribed by HCFA.

(h) *Waiver of full or simplified cost reporting for low program utilization.* (1) If the provider has had low utilization of covered services by Medicare beneficiaries (as determined by the intermediary) and has received correspondingly low interim payments for the cost reporting period, the intermediary may waive a full cost report or the simplified cost report described in

§ 413.321 if it decides that it can determine, without a full or simplified report, the reasonable cost of covered services provided during that period.

(2) If a full or simplified cost report is waived, the provider must submit within the same time period required for full or simplified cost reports:

(i) The cost reporting forms prescribed by HCFA for this situation; and

(ii) Any other financial and statistical data the intermediary requires.

[51 FR 34793, Sept. 30, 1986, as amended at 57 FR 39829, Sept. 1, 1992; 59 FR 26964, May 25, 1994; 60 FR 33125, 33136, 33143, June 27, 1995; 60 FR 37594, July 21, 1995; 62 FR 31, Jan. 2, 1997]

Subpart C—Limits on Cost Reimbursement

§ 413.30 Limitations on payable costs.

(a) *Introduction*—(1) *Scope.* This section implements section 1861(v)(1)(A) of the Act by setting forth the general rules under which HCFA may establish limits on SNF and HHA costs recognized as reasonable in determining Medicare program payments. It also sets forth rules governing exemptions and exceptions to limits established under this section that HCFA may make as appropriate in considering special needs or situations.

(2) *General principle.* Payable SNF and HHA costs may not exceed the costs HCFA estimates to be necessary for the efficient delivery of needed health care services. HCFA may establish estimated cost limits for direct or indirect overall costs or for costs of specific services or groups of services. HCFA imposes these limits prospectively and may calculate them on a per admission, per discharge, per diem, per visit, or other basis.

(b) *Procedure for establishing limits.* (1) In establishing limits under this section, HCFA may classify SNFs and HHAs by factors that HCFA finds appropriate and practical, including the following:

(i) Type of services furnished.

(ii) Geographical area where services are furnished, allowing for grouping of noncontiguous areas having similar demographic and economic characteristics.

(iii) Size of institution.

(iv) Nature and mix of services furnished.

(v) Type and mix of patients treated.

(2) HCFA bases its estimates of the costs necessary for efficient delivery of health services on cost reports or other data providing indicators of current costs. HCFA adjusts current and past period data to arrive at estimated costs for the prospective periods to which limits are applied.

(3) Before the beginning of a cost period to which revised limits will be applied, HCFA publishes a notice in the FEDERAL REGISTER, establishing cost limits and explaining the basis on which they are calculated.

(4) In establishing limits under paragraph (b)(1) of this section, HCFA may find it inappropriate to apply particular limits to a class of SNFs or HHAs due to the characteristics of the SNF or HHA class, the data on which HCFA bases those limits, or the method by which HCFA determines the limits. In these cases, HCFA may exclude that class of SNFs or HHAs from the limits, explaining the basis of the exclusion in the notice setting forth the limits for the appropriate cost reporting periods.

(c) *Requests regarding applicability of cost limits.* For cost reporting periods beginning before July 1, 1998, a SNF may request an exception or exemption to the cost limits imposed under this section. An HHA may request only an exception to the cost limits. The SNF or HHA must make its request to its fiscal intermediary within 180 days of the date on the intermediary's notice of program pay.

(1) *Home health agencies.* The intermediary makes a recommendation on the HHA's request to HCFA, which makes the decision. HCFA responds to the request within 180 days from the date HCFA receives the request from the intermediary. The intermediary notifies the HHA of HCFA's decision. The time required by HCFA to review the request is considered good cause for the granting of an extension of the time limit for the HHA to apply for a PRRB review, as specified in § 405.1841 of this chapter. HCFA's decision is subject to review under subpart R of part 405 of this chapter.

(2) *Skilled nursing facilities.* The intermediary makes the final determination on the SNF's request and notifies the SNF of its determination within 90 days from the date that the intermediary receives the request from the SNF. If the intermediary determines that the SNF did not provide adequate documentation from which a proper determination can be made, the intermediary notifies the SNF that the request is denied. The intermediary also notifies the SNF that it has 45 days from the date on the intermediary's denial letter to submit a new exception request with the complete documentation and that otherwise, the denial is the final determination. The time required by the intermediary to review the request is considered good cause for the granting of an extension of the time limit for the SNF to apply for a PRRB review, as specified in §405.1841 of this chapter. The intermediary's determination is subject to review under subpart R of part 405 of this chapter.

(d) *Exemptions.* Exemptions from the limits imposed under this section may be granted to a new SNF with cost reporting periods beginning before July 1, 1998 as stated in §413.1(g)(1). A new SNF is a provider of inpatient services that has operated as the type of SNF (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than 3 full years. An exemption granted under this paragraph expires at the end of the SNF's first cost reporting period beginning at least 2 years after the provider accepts its first inpatient.

(e) *Exceptions.* Limits established under this section may be adjusted upward for a SNF or HHA under the circumstances specified in paragraphs (e)(1) through (e)(5) of this section. An adjustment is made only to the extent that the costs are reasonable, attributable to the circumstances specified, separately identified by the SNF or HHA, and verified by the intermediary.

(1) *Atypical services.* The SNF or HHA can show that the—

(i) Actual cost of services furnished by a SNF or HHA exceeds the applicable limit because the services are atypical in nature and scope, compared to the services generally furnished by SNFs or HHAs similarly classified; and

(ii) Atypical services are furnished because of the special needs of the patients treated and are necessary in the efficient delivery of needed health care.

(2) *Extraordinary circumstances.* The SNF or HHA can show that it incurred higher costs due to extraordinary circumstances beyond its control. These circumstances include, but are not limited to, strikes, fire, earthquake, flood, or other unusual occurrences with substantial cost effects.

(3) *Areas with fluctuating populations.* The SNF or HHA meets the following conditions:

(i) Is located in an area (for example, a resort area) that has a population that varies significantly during the year.

(ii) Is furnishing services in an area for which the appropriate health planning agency has determined does not have a surplus of beds or services and has certified that the beds or services furnished by the SNF or HHA are necessary.

(iii) Meets occupancy or capacity standards established by the Secretary.

(4) *Medical and paramedical education.* The SNF or HHA can demonstrate that, if compared to other SNFs or HHAs in its group, it incurs increased costs for services covered by limits under this section because of its operation of an approved education program specified in §413.85.

(5) *Unusual labor costs.* The SNF or HHA has a percentage of labor costs that varies more than 10 percent from that included in the promulgation of the limits.

(f) *Operational review.* Any SNF or HHA that applies for an exception to the limits established under paragraph (e) of this section must agree to an operational review at the discretion of HCFA. The findings from this review may be the basis for recommendations for improvements in the efficiency and economy of the SNF's or the HHA's operations. If recommendations are made, any future exceptions are contingent on the SNF's or HHA's implementation of these recommendations.

[64 FR 42612, Aug. 5, 1999]

§413.35 Limitations on coverage of costs: Charges to beneficiaries if cost limits are applied to services.

(a) *Principle.* A provider of services that customarily furnishes an individual items or services that are more expensive than the items or services determined to be necessary in the efficient delivery of needed health services described in §413.30, may charge an individual entitled to benefits under Medicare for such more expensive items or services even though not requested by the individual. The charge, however, may not exceed the amount by which the cost of (or, if less, the customary charges for) such more expensive items or services furnished by such provider in the second cost reporting period immediately preceding the cost reporting period in which such charges are imposed exceeds the applicable limit imposed under the provisions of §413.30. This charge may be made only if—

(1) The intermediary determines that the charges have been calculated properly in accordance with the provisions of this section;

(2) The services are not emergency services as defined in paragraph (d) of this section;

(3) The admitting physician has no direct or indirect financial interest in such provider;

(4) HCFA has provided notice to the public through notice in a newspaper of general circulation servicing the provider's locality and such other notice as the Secretary may require, of any charges the provider is authorized to impose on individuals entitled to benefits under Medicare on account of costs in excess of the costs determined to be necessary in the efficient delivery of needed health services under Medicare; and

(5) The provider has, in the manner described in paragraph (e) of this section, identified such charges to such individual or person acting on his behalf as charges to meet the costs in excess of the costs determined to be necessary in the efficient delivery of needed health services under Medicare.

(b) *Provider request to charge beneficiaries for costs in excess of limits.* (1) If a provider's actual costs (or, if less, the customary charges) in the second preceding cost period exceed the prospective limits established for such costs, the intermediary will, at the provider's request, validate in advance the charges that may be made to the beneficiaries for the excess.

(2) If a provider does not have a second preceding cost period and is a new provider as defined in §413.30(e), the provider, subject to validation by the intermediary, will estimate the current cost of the service to which a limit is being applied. Such amount will be adjusted to an amount equivalent to costs in the second preceding year by use of a factor to be developed based on estimates of cost increases during the preceding two years and published by SSA or HCFA. The amount thus derived will be used in lieu of the second preceding cost period amount in determining the charge to the beneficiary.

(3) To obtain consideration of such a request, the provider must submit to the intermediary a statement indicating the chagre for which it is seeking validation and providing the data and method used to determine the amount. Such statement should include the—

(i) Provider's name and number;

(ii) Identity of class and prospective cost limit for the class in which the provider has been included;

(iii) Amount of charge and cost period in which the charge is to be imposed;

(iv) Cost and customary charge for items and services furnished to beneficiaries; and

(v) Cost period ending date of the second reporting period immediately preceding the cost period in which the charge is to be imposed. The intermediary may request such additional information as it finds necessary with respect to the request.

(c) *Provider charges.*— (1) *Establishing the charges.* If the actual cost incurred (or, if less, the customary charges) in the prior period determined under paragraph (a) of this section exceeds the limits applicable to the pertinent period, the provider may charge the beneficiary to the extent costs in the second preceding cost reporting period (or the equivalent when there is no second preceding period) exceed the current cost limits. (Data from the most

recently submitted appropriate cost report will be used in determining the actual cost.) For example, if a limit of $58 per day is applied to the cost of general routine services for the provider's cost reporting period starting in calendar year 1975 and if the provider's actual general routine cost in the second preceding reporting period, that is, the reporting period starting in calendar year 1973, was $60 per day, the provider (after first having obtained intermediary validation and subject to the considerations and requirements specified in paragraph (a) of this section) may charge Medicare Part A beneficiaries up to $2 per day for general routine services.

(2) *Adjusting cost.* Program reimbursement for the costs to which limits imposed under §413.30 are applied in any cost reporting period will not exceed the lesser of the provider's actual cost or the limits imposed under §413.30. If program reimbursement for items or services to which such limits are applied plus the charges to beneficiaries for such items or services imposed under this section exceed the provider's actual cost for such items or services, program payment to the provider will be reduced to the extent program payment plus charges to the beneficiaries exceed actual cost. If the provider's actual cost for general routine services in 1975 was $57,000, the cost limit was $58,000, and billed charges to Medicare Part A beneficiaries were $2,000, the provider would receive $55,000 from the program ($57,000 actual cost minus the $2,000 in charges to the beneficiaries).

(d) *Definition of emergency services.* For purposes of paragraph (a)(2) of this section, emergency services are those hospital services that are necessary to prevent the death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital (as determined under §424.106 of this chapter) available and equipped to furnish such services. If an individual has been admitted to such hospital as an inpatient because of an emergency, the emergency will be deemed to continue until it is safe from a medical standpoint to move the individual to another hospital or other institution or to discharge him.

(e) *Identification of charges to individual.* For purposes of paragraph (a)(5) of this section, a provider must give or send to the individual or his representative, a schedule of all items and services that the individual might need and for which the provider imposes charges under this section, and the charge for each. Such schedule must specify that the charges are necessary to meet the costs in excess of the costs determined to be necessary in the efficient delivery of needed health services under Medicare and include such other information as HCFA considers necessary to protect the individual's rights under this section. The provider, in arranging for the individual's admission, first service, or start of care, must give or send this schedule to the individual or his representative when arrangements are being made for such services or if this is not feasible, as soon thereafter as is practicable but no later than at the initiation of services.

[51 FR 34793, Sept. 30, 1986, as amended at 53 FR 6648, Mar. 20, 1988; 60 FR 45849, Sept. 1, 1995]

§ 413.40 Ceiling on the rate of increase in hospital inpatient costs.

(a) *Introduction*—(1) *Scope.* This section implements section 1886(b) of the Act, establishing a ceiling on the rate of increase in operating costs per case for hospital inpatient services furnished to Medicare beneficiaries that will be recognized as reasonable for purposes of determining the amount of Medicare payment. This rate-of-increase ceiling applies to hospital cost reporting periods beginning on or after October 1, 1982. This section also sets forth rules governing exemptions from and adjustments to the ceiling.

(2) *Applicability.* (i) This section is not applicable to—

(A) Hospitals reimbursed in accordance with section 1814(b)(3) of the Act or under State reimbursement control systems that have been approved under section 1886(c) of the Act and subpart C of part 403 of this chapter; or

(B) Hospitals that are paid under the prospective payment systems for inpatient hospital services in accordance

with section 1886 (d) and (g) of the Act and part 412 of this chapter.

(ii) For cost reporting periods beginning on or after October 1, 1983, this section applies to hospitals excluded from the prospective payment system in accordance with §412.23 of this chapter, and psychiatric and rehabilitation units excluded from the prospective payment system in accordance with §§412.25 through 412.30 of this chapter.

(3) *Definitions.* As used in this section—

Ceiling is the aggregate upper limit on the amount of a hospital's net Medicare inpatient operating costs that the program will recognize for payment purposes. For each cost reporting period, the ceiling is determined by multiplying the updated target amount, as defined in this paragraph, for that period by the number of Medicare discharges during that period. For a hospital-within-a-hospital, as described in §412.22(e) of this chapter, the number of Medicare discharges in a cost reporting period does not include discharges of a patient to another hospital in the same building on or on the same campus, if—

(A) The patient is subsequently readmitted to the hospital-within-a-hospital directly from the other hospital; and

(B) The hospital-within-a-hospital has discharged to the other hospital and subsequently readmitted more than 5 percent (that is, in excess of 5.0 percent) of the total number of inpatients discharged from the hospital-within-a-hospital in that cost reporting period.

Date of discharge is the earliest of the following dates:

(A) The date the patient has exhausted Medicare Part A hospital inpatient benefits (including the election to use lifetime reserve days) during his or her spell of illness.

(B) The date the patient is formally released as specified in §412.4(a)(1) of this chapter.

(C) The date the patient is transferred to another facility.

(D) The date the patient dies.

Market basket index is HCFA's projection of the annual percentage increase in hospital inpatient operating costs. The market basket index is a wage and price index that incorporates weighted indicators of changes in wages and prices that are representative of the mix of goods and services included in the most common categories of hospital inpatient operating costs subject to the ceiling, as described in paragraph (c)(1) of this section.

Net inpatient operating costs include the costs of certain preadmission services as specified in §413.40(c)(2), the costs of routine services, ancillary services, and intensive care services (as defined in §413.53(b)) incurred by a hospital in furnishing covered inpatient services to Medicare beneficiaries. Net inpatient operating costs exclude capital-related costs as described in §413.130, the costs of approved medical education programs as described in §§413.85 and 413.86, and heart, kidney, and liver acquisition costs incurred by approved transplantation centers. These costs are identified and excluded from inpatient operating costs before the application of the ceiling.

Rate-of-increase percentage is the percentage by which each hospital's target amount from the preceding Federal fiscal year is increased.

Target amount is the per discharge (case) limitation, derived from the hospital's allowable net Medicare inpatient operating costs in the hospital's base year, and updated for each subsequent hospital cost reporting period by the appropriate annual rate-of-increase percentage.

Update adjustment percentage is the percentage by which a hospital's allowable inpatient operating service costs for the 12-month cost reporting period beginning in Federal fiscal year 1990 exceeds the hospital's ceiling for that period.

Update factor is the decimal equivalent of the rate-of-increase percentage. The update factor is the value by which a hospital's target amount for the preceding year is multiplied in order to determine the target amount for the following year. For example, if the rate-of-increase percentage for a year is 2.7 percent, the update factor for that year is 1.027.

(b) *Cost reporting periods subject to the rate-of-increase ceiling.* (1) *Base period.* Each hospital's target amount is based

on its allowable net inpatient operating costs per case from the cost reporting period of at least 12 months immediately preceding the first cost reporting period subject to the rate-of-increase ceiling established under this section. If the immediately preceding cost reporting period is a short reporting period (fewer than 12 months), the first period of at least 12 months subsequent to that short period is the base period.

(i) The target amount established under this provision remains applicable to a hospital or excluded hospital unit, as described in §§ 412.25 through 412.30 of this chapter, despite intervening cost reporting periods during which the hospital or excluded hospital unit is not subject to the ceiling as a result of other provisions of the law or regulations, or nonparticipation in the Medicare program, unless the hospital or excluded hospital unit qualifies as a new hospital or excluded part hospital unit under the provisions of paragraph (f) of this section.

(ii) The base period for a newly established excluded unit is the first cost reporting period of at least 12 months following the unit's certification to participate in the Medicare program.

(iii) When the operational structure of a hospital or unit changes (that is, a freestanding hospital becomes an excluded unit or an excluded unit becomes a freestanding hospital, or an entity of a multicampus hospital becomes a newly created hospital or unit or a hospital or unit becomes a part of a multicampus hospital), the base period for the hospital or unit that changed its operational structure is the first cost reporting period of at least 12 months effective with the revised Medicare certification classification.

(iv) *Request for rebased target amount for the cost reporting period beginning on or after October 1, 1997 and on or before September 30, 1998.* Except for qualified long-term care hospitals as defined in paragraph (b)(1)(v) of this section, each hospital or unit under present or previous ownership that received payment under section 1886(b) of the Act during cost reporting periods beginning before October 1, 1990, may submit a request to its fiscal intermediary to rebase its target amount. The request must be received by the fiscal intermediary by the later of November 1, 1997 or 60 days before the beginning of its cost reporting period beginning during fiscal year 1998. The rebased target amount for the cost reporting period beginning during fiscal year 1998 is determined as follows:

(A) Determine the hospital's inpatient operating costs per case for each of the five most recent settled cost reports as of August 5, 1997.

(B) For each of the five cost reports, update the operating costs per case by the applicable update factors up to the hospital's cost reporting period beginning during FY 1998.

(C) Exclude the highest and lowest of the five updated amounts determined under paragraph (b)(1)(iv)(B) of this section.

(D) Compute the average for the remaining three updated amounts for operating cost per case.

(v) *Request by qualified long-term care hospital.* A qualified long-term care hospital may file a request to its fiscal intermediary for a rebased FY 1998 target amount. The request must be received by the fiscal intermediary by the later of November 1, 1997 or 60 days before the beginning of its cost reporting period beginning during fiscal year 1998. The rebased FY 1998 target amount is the hospital's FY 1996 inpatient operating costs updated to FY 1997. A qualified long-term care hospital means a long-term care hospital that meets the following two conditions for its two most recent settled cost reports as of August 5, 1997:

(A) Its Medicare inpatient operating costs exceed 115 percent of the ceiling.

(B) The hospital would have had a disproportionate patient percentage (as defined in § 412.106) equal to or greater than 70 percent if it were a prospective payment hospital.

(2) *Periods subject to the ceiling.* The ceiling established under this section applies to all cost reporting periods that—

(i) Begin on or after October 1, 1982; and

(ii) Immediately follow the base period established under paragraph (b)(1) of this section unless the exception in

paragraph (b)(3) of this section is applicable.

(3) *Periods of other than 12 months.* The ceiling established under this section does not apply to cost reporting periods of fewer than 12 months that occur in conjunction with a change in operation of the facility, as defined in paragraph (b)(1)(iii) of this section, as a result of changes in ownership, merger, or consolidation. However, the ceiling applies to cost reporting periods of fewer than 12 months that result solely from the approval of a hospital's request for a change in accounting cycle, as specified in §413.24(f)(3).

(c) *Costs subject to the ceiling*—(1) *Applicability.* The ceiling established under this section applies to net operating costs incurred by a hospital in furnishing inpatient hospital services to Medicare beneficiaries.

(2) Preadmission services otherwise payable under Medicare Part B furnished to a beneficiary during the calendar day immediately preceding the date of the beneficiary's admission to the hospital that meet the following conditions:

(i) The services are furnished by the hospital or any entity wholly owned or operated by the hospital. An entity is wholly owned by the hospital if the hospital is the sole owner of the entity. An entity is wholly operated by a hospital if the hospital has exclusive responsibility for conducting and overseeing the entity's routine perations, regardless of whether the hospital also has policymaking authority over the entity.

(ii) For services furnished after January 1, 1991, the services are diagnostic (including clinical diagnostic laboratory tests).

(iii) For services furnished on or after October 1, 1991, the services are furnished in connection with the principal diagnosis that requires the beneficiary to be admitted as an inpatient and are not the following:

(A) Ambulance services.

(B) Maintenance renal dialysis.

(3) *Rate-of-increase percentages and update factors.* The applicable rate-of-increase percentages and update factors are determined as follows:

(i) *Federal fiscal year 1986.* The applicable rate-of-increase percentage for cost reporting periods beginning on or after October 1, 1985 and before September 30, 1986 is five twenty-fourths of one percent, and the update factor is 1.00208333. For purposes of determining the target amount for cost reporting periods beginning on or after October 1, 1986, the applicable percentage increase for cost reporting periods beginning during Federal fiscal year 1986 is deemed to have been one-half percent, and the update factor is 1.005.

(ii) *Federal fiscal year 1987.* The applicable rate-of-increase percentage for cost reporting periods beginning on or after October 1, 1986 and before September 30, 1987 is 1.15 percent; the update factor is 1.0115.

(iii) *Federal fiscal year 1988.* The applicable rate-of-increase percentage for cost reporting periods beginning on or after October 1, 1987 and before October 1, 1988 is 2.3238 percent; the update factor is 1.023238. For purposes of updating the target amount for cost reporting periods beginning on or after October 1, 1988, the rate-of-increase percentage for cost reporting periods beginning during FY 1988 is deemed to have been 2.7 percent; the update factor is deemed to have been 1.027.

(iv) *Federal fiscal year 1989 through Federal fiscal year 1993.* The applicable rate-of-increase percentage for cost reporting periods beginning on or after October 1, 1988, and before October 1, 1993, is the percentage increase projected by the hospital market basket index (as defined in paragraph (a)(3) of this section).

(v) *Federal fiscal year 1994 through Federal fiscal year 1997.* The applicable rate-of-increase percentage for cost reporting periods beginning on or after October 1, 1993, and before October 1, 1998, is the market basket percentage increase minus the lesser of, 1 percentage point, or the percentage point difference between 10 percent and the hospital's ''update adjustment percentage'' (as defined in paragraph (a)(3) of this section); for hospitals with an ''update adjustment percentage'' of at least 10 percent, the applicable rate-of-increase percentage is the market basket percentage increase. The ''update adjustment percentage'' is increased in each Federal fiscal year by the sum of

the hospital's applicable reductions applied to the market basket percentage increase for previous Federal fiscal years.

(vi) *Federal fiscal year 1998.* The applicable rate-of-increase percentage for cost reporting periods beginning on or after October 1, 1997 is 0 percent.

(vii) *Federal fiscal year 1999 through Federal fiscal year 2002.* The applicable rate-of-increase percentage for cost reporting periods beginning on or after October 1, 1998, and before October 1, 2002, based n data from the most recent available cost report, is:

(A) The percentage increase in the market basket, if inpatient operating costs are equal to or exceed the ceiling amount by 10 percent or more of the ceiling.

(B) The percentage increase in the market basket minus .25 percentage points for each percentage point by which inpatient operating costs are less than 10 percent over the ceiling (but not less than 0), if inpatient operating costs exceed the ceiling by less than 10 percent of the ceiling.

(C) The greater of the percentage increase in the market basket minus 2.5 percentage points or 0 percent, if inpatient operating costs are equal to or less than the ceiling but greater than 66.7 percent of the ceiling.

(D) 0 percent, if inpatient operating costs do not exceed 66.7 percent of the ceiling.

(viii) *Federal fiscal year 2003 and following.* The applicable rate-of-increase percentage for cost reporting periods beginning on or after October 1, 2002, is the percentage increase projected by the hospital market basket index.

(4) *Target amounts.* The intermediary will establish a target amount for each hospital. The target amount for a cost reporting period is determined as follows:

(i) Except as provided in paragraph (c)(4)(iv) of this section, and subject to the provisions of paragraph (c)(4)(iii) of this section, for the first cost reporting period to which this ceiling applies, the target amount equals the hospital's allowable net inpatient operating costs per case for the hospital's base period increased by the update factor for the subject period.

(ii) Subject to the provisions of paragraph (c)(4)(iii) of this section, for subsequent cost reporting periods, the target amount equals the hospital's target amount for the previous cost reporting period increased by the update factor for the subject cost reporting period, unless the provisions of paragraph (c)(5)(ii) of this section apply.

(iii) In the case of a psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital, the target amount is the lower of—

(A) The hospital-specific target amount (the net allowable costs in a base period increased by the applicable update factors); or

(B) One of the following for the applicable cost reporting period—

(*1*) For cost reporting periods beginning during fiscal year 1998, the 75th percentile of target amounts for hospitals in the same class (psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital) for cost reporting periods ending during FY 1996, increased by the applicable market basket percentage up to the first cost reporting period beginning on or after October 1, 1997.

(*2*) For cost reporting periods beginning during fiscal years 1999 through 2002, the amount determined under paragraph (c)(4)(iii)(B)(*1*) of this section, increased by the market basket percentage up through the subject period, subject to the provisions of paragraph (c)(4)(iv) of this section.

(iv) For purposes of the limits on target amounts established under paragraph (c)(4)(iii) of this section, each hospital or unit that qualifies for exclusion as a member of only one class of excluded facility (psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital) will be subject to the limit applicable to that class. If a hospital or unit qualifies to be classified in more than one way under the exclusion criteria in subpart B of part 412 of this chapter, the hospital's or unit's target amount may not exceed the lowest applicable limit.

(v) In the case of a hospital that received payments under paragraph (f)(2)(ii) of this section as a newly created hospital or unit, to determine the

hospital's target amount for the hospital's third 12-month cost reporting period, the payment amount determined under paragraph (f)(2)(ii) of this section for the preceding cost report period is updated to the third cost reporting period.

(5) *Applicable update factor.* (i) The applicable update factor is derived from the prospectively determined rate-of-increase percentage published by HCFA. The update factor for each Federal fiscal year is applied prospectively to the target amount for each cost reporting period beginning during the Federal fiscal year.

(ii) In the case of cost reporting periods of less than 12 months, the target amount determined for a hospital's first cost reporting period beginning in a Federal fiscal year applies to subsequent periods beginning in the same Federal fiscal year.

(d) *Application of the target amount in determining the amount of payment.* (1) *General process.* (i) At the end of each cost reporting period subject to this section, the hospital's intermediary will compare a hospital's allowable net inpatient operating costs with that hospital's ceiling (as defined in paragraph (a)(3) of this section) for that period.

(ii) The hospital's actual allowable costs will be determined without regard to the lesser of cost or charges provisions of §413.13, and in accordance with the provisions of paragraphs (d)(2) or (d)(3) of this section, as applicable.

(2) *Net inpatient operating costs are less than or equal to the ceiling.* For cost reporting periods beginning on or after October 1, 1997, if a hospital's allowable net inpatient operating costs do not exceed the hospital's ceiling, payment to the hospital will be determined on the basis of the lower of the—

(i) Net inpatient operating costs plus 15 percent of the difference between inpatient operating costs and the ceiling; or

(ii) Net inpatient operating costs plus 2 percent of the ceiling.

(3) *Net inpatient operating costs are greater than the ceiling.* For cost reporting periods beginning on or after October 1, 1997—

(i) If a hospital's allowable net inpatient operating costs do not exceed 110 percent of the ceiling (or the adjusted ceiling, if applicable), payment will be the ceiling (or the adjusted ceiling, if applicable);

(ii) If a hospital's allowable net inpatient operating costs are greater than 110 percent of the ceiling (or the adjusted ceiling, if applicable), payment will be the ceiling (or the adjusted ceiling, if applicable) plus the lesser of:

(A) 50 percent of the allowable net inpatient operating costs in excess of 110 percent of the ceiling (or the adjusted ceiling, if applicable); or

(B) 10 percent of the ceiling (or the adjusted ceiling, if applicable).

(4) *Continuous improvement bonus payments.* For cost reporting periods beginning on or after October 1, 1997, eligible hospitals (as defined in paragraph (d)(5) of this section) receive payments in addition to those in paragraph (d)(2) of this section, as applicable. These payments are equal to the lesser of—

(i) 50 percent of the amount by which the operating costs are less than the expected costs for the period; or

(ii) 1 percent of the ceiling.

(5) *Eligibility requirements for continuous improvement bonus payments.* To qualify, a hospital must have been paid as a prospective payment excluded hospital for at least three full cost reporting periods prior to the applicable period, and the hospital's operating costs per discharge for the period must be less than the least of the following:

(i) The hospital's target amount.

(ii) The hospital's trended costs.

(A) For a hospital for which its cost reporting period ending during fiscal year 1996 was its third or subsequent full cost reporting period, trended costs are the lesser of the allowable inpatient operating costs per discharge or the target amount for the cost reporting period ending in fiscal year 1996, increased in a compounded manner for each succeeding fiscal year by the market basket percentage increase;

(B) For all other hospitals, trended costs are the allowable inpatient operating costs per discharge for its third full cost reporting period increased in a compounded manner for each succeeding fiscal year by the market basket increase.

(iii) The hospital's expected costs. The hospital's expected costs are the

lesser of its allowable inpatient operating costs per discharge or the target amount for the previous cost reporting period, updated by the market basket percentage increase for the fiscal year.

(e) *Hospital requests regarding adjustments to the payment allowed under the rate-of-increase ceiling.* (1) *Timing of application.* A hospital may request an adjustment to the rate-of-increase ceiling imposed under this section. The hospital's request must be received by the hospital's fiscal intermediary no later than 180 days after the date on the intermediary's initial notice of amount of program reimbursement (NPR) for the cost reporting period for which the hospital requests an adjustment.

(2) *Intermediary recommendation.* Unless HCFA has authorized the intermediary to make the decision, the intermediary makes a recommendation on the hospital's request to HCFA, which makes the decision. HCFA issues a decision to the intermediary no later than 180 days after receipt of the completed application and the intermediary's recommendation.

(3) *Intermediary decision.* If HCFA has authorized the intermediary to make the decision, the intermediary issues a decision no later than 180 days after receipt of the completed application.

(4) *Notification and review.* (i) The intermediary notifies the hospital of the decision, including a full explanation of the grounds for the decision. A decision issued under paragraph (e)(2) or (e)(3) of this section is considered final unless the hospital submits additional information and requests a review of the decision no later than 180 days after the date on the intermediary's notice of the decision.

(ii) The final decision is subject to review under the provider reimbursement determination and appeal procedures in subpart R of part 405 of this chapter, provided the hospital has received an NPR for the cost reporting period in question, and the NPR disallows costs for which the hospital had requested an adjustment (see the definitions in § 405.1801(a) of this chapter and the provisions regarding a provider's right to a Board hearing in § 405.1835 of this chapter).

(5) *Extending time limit for PRRB review of NPR.* The time required to review the request is considered good cause for the granting of an extension of the time limit to apply for review of the notice of amount of program reimbursement by the Provider Reimbursement Review Board, as specified in § 405.1841(b) of this chapter.

(6) *Applicability.* The provisions in paragraphs (e)(1) through (e)(5) of this section apply to a hospital's initial request for an adjustment and to a request for a review of the original decision based on additional data.

(f) *Comparison to the target amount for new hospitals and units*—(1) *New hospitals and units*—(i) *New hospitals.* For purposes of this section, a new hospital is a provider of hospital inpatient services that—

(A) Has operated as the type of hospital for which HCFA granted it approval to participate in the Medicare program, under present or previous ownership (or both), for less than 2 full years; and

(B) Has provided the type of hospital inpatient services for which HCFA granted it approval to participate in the Medicare program, for less than 2 years.

(ii) *New units.* A newly established unit that is excluded from the prospective payments system under the provisions of §§ 412.25 through 412.30 of this chapter does not qualify for the exemption afforded to a new hospital under paragraph (f)(2)(i) of this section unless the unit is located in an acute care hospital that, if it were subject to the provisions of this section, would qualify as a new hospital under paragraph (f)(1)(i) of this section.

(2) *Comparison*—(i) *Exemptions.* (A) A new children's hospital is exempt from the rate-of-increase ceiling imposed under this section. The exemption begins when the hospital accepts its first patient and ends at the end of the first cost reporting period ending at least 2 years after the hospital accepts its first patient. The first cost reporting period of at least 12 months beginning at least 1 year after the hospital accepts its first patient is the base year, in accordance with paragraph (b) of this section.

(B) Within 180 days of the date a hospital is excluded from the prospective

payment system, the intermediary determines whether the hospital is exempt from the rate-of-increase ceiling. The intermediary notifies the hospital of its determination and the hospital's base period.

(C) A decision issued under paragraph (f)(2)(ii)(B) of this section is considered final unless the hospital submits additional information and requests a review of the decision no later than 180 days after the date on the intermediary's notice of the decision. The final decision is subject to review under subpart R of part 405 of this chapter, provided the hospital has received a notice of program reimbursement (NPR) for the cost reporting period in question and the NPR does not reflect an exemption (see the definitions in §405.1801(a) of this chapter and the provisions regarding a provider's right to a Board hearing in §405.1835 of this chapter).

(ii) *Median target amount.* (A) For cost reporting periods beginning on or after October 1, 1997, the amount of payment for a new psychiatric hospital or unit, a new rehabilitation hospital or unit, or a new long-term care hospital that was not paid as an excluded hospital prior to October 1, 1997, is the lower of the hospital's net inpatient operating cost per case or 110 percent of the national median of the target amounts for the class of excluded hospitals and units (psychiatric, rehabilitation, long-term care) as adjusted for differences in wage levels and updated to the first cost reporting period in which the hospital receives payment. The second cost reporting period is subject to the same target amount as the first cost reporting period.

(B) The national median of the target amounts is the FY 1996 median target amount—

(*1*) Adjusted to account for differences in area wage levels;

(*2*) Updated by the market basket percentage increase to the fiscal year in which the hospital first received payments as an excluded provider.

(3) *Risk-basis HMOs.* Items or services that are furnished to beneficiaries enrolled in an HMO by a hospital that is either owned or operated by a risk-basis HMO or related to a risk-basis HMO by common ownership or control are exempt from the rate-of-increase ceiling (see the definition of an entity with a risk sharing contract in §417.401 of this chapter).

(g) *Adjustments*—(1) *General rules.* (i) HCFA adjusts the amount of the operating costs considered in establishing the rate-of-increase ceiling for one or more cost reporting periods, including both periods subject to the ceiling and the hospital's base period, under the circumstances specified in paragraphs (g)(2), (g)(3), and (g)(4) of this section.

(ii) When the hospital requests an adjustment, HCFA makes an adjustment only to the extent that the hospital's operating costs are reasonable, attributable to the circumstances specified separately, identified by the hospital, and verified by the intermediary.

(iii) When the hospital requests an adjustment, HCFA makes an adjustment only if the hospital's operating costs exceed the rate-of-increase ceiling imposed under this section.

(iv) In the case of a psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital, the amount of payment under paragraph (g)(3) of this section may not exceed the payment amount based on the target amount determined under paragraph (c)(4)(iii) of this section.

(v) In the case of a hospital or unit that received a revised FY 1998 target amount under the rebasing provisions of paragraph (b)(1)(iv) of this section, the amount of an adjustment payment for a cost reporting period is based on a comparison of the hospital's operating costs for the cost reporting period to the average costs and statistics for the cost reporting periods used to determine the FY 1998 rebased target amount.

(2) *Extraordinary circumstances.* HCFA may make an adjustment to take into account unusual costs (in either a cost reporting period subject to the ceiling or the hospital's base period) due to extraordinary circumstances beyond the hospital's control. These circumstances include, but are not limited to, strikes, fire, earthquakes, floods, or similar unusual occurrences with substantial cost effects.

(3) *Comparability of cost reporting periods*—(i) *Adjustment for distortion.* HCFA may make an adjustment to take into

account factors that would result in a significant distortion in the operating costs of inpatient hospital services between the base year and the cost reporting period subject to the limits.

(ii) *Factors.* The adjustments described in paragraph (g)(3)(i) of this section, include, but are not limited to, adjustments to take into account:

(A) FICA taxes (if the hospital did not incur costs for FICA taxes in its base period).

(B) Services billed under part B of Medicare during the base period, but paid under part A during the subject cost reporting period.

(C) Malpractice insurance costs (if malpractice costs were not included in the base year operating costs).

(D) Increases in service intensity or length of stay attributable to changes in the type of patient served.

(E) A change in the inpatient hospital services that a hospital provides, and that are customarily provided directly by similar hospitals, such as an addition or discontinuation of services or treatment programs.

(F) The manipulation of discharges to increase reimbursement.

(iii) *Adjusting operating costs.* Without a formal request from a hospital, HCFA may adjust the amount of operating costs determined under paragraph (c)(1) of this section to take into account certain adjustments. These adjustments include, but are not limited to, adjustments under paragraphs (g)(3)(ii)(A), (B), (C), (E), and (F) of this section.

(4) *Significant wage increase.* (i) *Criteria.* HCFA may make an adjustment to take into account a significant increase in wages occurring between the base period and the cost reporting period subject to the ceiling if there is a significant increase in the average hourly wage for the geographic area in which the hospital is located (determined by reference to the wage index for prospective payment hospitals without regard to geographic reclassifications under sections 1886(d)(8) and (10) of the Act). For this purpose, there is a significant wage increase if the wage index value based on wage survey data collected for the cost reporting period subject to the ceiling is at least 8.0 percent higher than the wage index value based on survey data collected for the base year cost reporting period. If survey data are not available for the cost reporting periods used in the comparison, the wage index value based on the latest available survey data collected prior to that cost reporting period is used.

(ii) *Amount of the adjustment.* The adjustment for a significant wage increase equals the amount by which the lesser of the following calculations exceeds 108 percent of the increase in the national average hourly earnings for hospital workers:

(A) The rate of increase in the average hourly wage in the geographic area (determined by applying the applicable increase in the area wage index value to the rate of increase in the national average hourly earnings for hospital workers).

(B) The rate of increase in the hospital's average hourly wage.

(5) *Adjustment limitations.* For cost reporting periods beginning on or after October 1, 1993, and before October 1, 2003, the payment reductions under paragraph (c)(3)(v) through (c)(3)(vii) of this section will not be considered when determining adjustments under this paragraph.

(h) [Reserved]

(i) *Assignment of a new base period.* (1) *General rule.* (i) Effective with cost reporting periods beginning on or after April 1, 1990, HCFA may assign a new base period to establish a revised ceiling if the new base period is more representative of the reasonable and necessary cost of furnishing inpatient services and all the following conditions apply:

(A) The actual allowable inpatient costs of the hospital in the cost reporting period that would be affected by the revised ceiling exceed the target amount established under paragraph (c) of this section.

(B) The hospital documents that the higher costs are the result of substantial and permanent changes in furnishing patient care services since the base period. In making this determination, HCFA takes into consideration the following factors:

(*1*) Changes in the services provided by the hospital.

(*2*) Changes in applicable technologies and medical practices.

(*3*) Differences in the severity of illness among patients or types of patients served.

(C) The adjustments described in paragraph (g) of this section would not result in recognition of the reasonable and necessary costs of providing inpatient services.

(ii) The revised ceiling is based on the necessary and proper costs incurred during the new base period.

(A) Increases in overhead costs (for example, administrative and general costs and housekeeping costs) are not taken into consideration unless the hospital documents that these increases result from substantial and permanent changes in furnishing patient care services.

(B) In determining whether wage increases are necessary and proper, HCFA takes into consideration whether increases in wages and wage-related costs for hospitals in the labor market area exceed the national average increase.

(2) *New base period.* The new base period is the first cost reporting period that is 12 months or longer that reflects the substantial and permanent change.

(3) *New applicable rate-of-increase percentages and update factors.* The revised target amount resulting from the assignment of a new base period is increased by the applicable rate-of-increase percentages (update factors) described in paragraph (c)(3) of this section.

(j) *Reduction to capital-related costs.* For psychiatric hospital and units, rehabilitation hospitals and units, and long-term care hospitals, the amount otherwise payable for capital-related costs for hospital inpatient services is reduced by 15 percent for portions of cost reporting periods occurring on or after October 1, 1997 through September 30, 2002.

[58 FR 46340, Sept. 1, 1993, as amended at 59 FR 1659, Jan. 12, 1994; 59 FR 45401, Sept. 1, 1994; 60 FR 45849, Sept. 1, 1995; 61 FR 2725, Jan. 29, 1996; 61 FR 46225, Aug. 30, 1996; 62 FR 46032, Aug. 29, 1997; 63 FR 6868, Feb. 11, 1998; 63 FR 26358, May 12, 1998; 63 FR 41004, July 31, 1998; 64 FR 41541, July 30, 1999]

Subpart D—Apportionment

§ 413.50 Apportionment of allowable costs.

(a) Consistent with prevailing practice in which third-party organizations pay for health care on a cost basis, reimbursement under the Medicare program involves a determination of—

(1) Each provider's allowable costs for producing services; and

(2) The share of these costs which is to be borne by Medicare. The provider's costs are to be determined in accordance with the principles reviewed in the preceding discussion relating to allowable costs. The share to be borne by Medicare is to be determined in accordance with principles relating to apportionment of cost.

(b) In the study and consideration devoted to the method of apportioning costs, the objective has been to adopt methods for use under Medicare that would, to the extent reasonably possible, result in the program's share of a provider's total allowable costs being the same as the program's share of the provider's total services. This result is essential for carrying out the statutory directive that the program's payments to providers should be such that the costs of covered services for beneficiaries would not be passed on to nonbeneficiaries, nor would the cost of services for nonbeneficiaries be borne by the program.

(c) A basic factor bearing upon apportionment of costs is that Medicare beneficiaries are not a cross section of the total population. Nor will they constitute a cross section of all patients receiving services from most of the providers that participate in the program. Available evidence shows that the use of services by persons age 65 and over differs significantly from other groups. Consequently, the objective sought in the determination of the Medicare share of a provider's total costs means that the methods used for apportionment must take into account the differences in the amount of services received by patients who are beneficiaries and other patients serviced by the provider.

(d) The method of cost reimbursement most widely used at the present

time by third-party purchasers of inpatient hospital care apportions a provider's total costs among groups served on the basis of the relative number of days of care used. This method, commonly referred to as average-per-diem cost, does not take into account, variations in the amount of service which a day of care may represent and thereby assumes that the patients for whom payment is made on this basis are average in their use of service.

(e) In considering the average-per-diem method of apportioning cost for use under the program, the difficulty encountered is that the preponderance of presently available evidence strongly indicates that the over-age 65 patient is not typical from the standpoint of average-per-diem cost. On the average this patient stays in the hospital twice as long and therefore the ancillary services that he uses are averaged over the longer period of time, resulting in an average-per-diem cost for the aged alone, significantly below the average-per-diem for all patients.

(f) Moreover, the relative use of services by aged patients as compared to other patients differs significantly among institutions. Consequently, considerations of equity among institutions are involved as well as that of effectiveness of the apportionment method under the program in accomplishing the objective of paying each provider fully, but only for services to beneficiaries.

(g) A further consideration of long-range importance is that the relative use of services by aged and other patients can be expected to change, possibly to a significant extent in future years. The ability of apportionment methods used under the program to reflect such change is an element of flexibility which has been regarded as important in the formulation of the cost reimbursement principles.

(h) An alternative to the relative number of days of care as a basis for apportioning costs is the relative amount of charges billed by the provider for services to patients. The amount of charges is the basis upon which the cost of hospital care is distributed among patients who pay directly for the services they receive. Payment for services on the basis of charges applies generally under insurance programs in which individuals are indemnified for incurred expenses, a form of health insurance widely held throughout the United States. Also, charges to patients are commonly a factor in determining the amount of payment to hospitals under insurance programs providing service benefits, many of which pay ''costs or charges, whichever is less'' and some of which pay exclusively on the basis of charges. In all of these instances, the provider's own charge structure and method of itemizing services for the purpose of assessing charges is utilized as a measure of the amount of services received and as the basis for allocating responsibility for payment among those receiving the provider's services.

(i) An increasing number of third-party purchasers who pay for services on the basis of cost are developing methods that utilize charges to measure the amount of services for which they have responsibility for payment. In this approach, the amount of charges for such services as a proportion of the provider's total charges to all patients is used to determine the proportion of the provider's total costs for which the third-party purchaser assumes responsibility. The approach is subject to numerous variations. It can be applied to the total of charges for all services combined or it can be applied to components of the provider's activities for which the amount of costs and charges are ascertained through a breakdown of data from the provider's accounting records.

(j) For the application of the approach to components, which represent types of services, the breakdown of total costs is accomplished by ''cost-finding'' techniques under which indirect costs and nonrevenue activities are allocated to revenue producing components for which charges are made as services are furnished.

§ 413.53 Determination of cost of services to beneficiaries.

(a) *Principle.* Total allowable costs of a provider will be apportioned between program beneficiaries and other patients so that the share borne by the program is based upon actual services received by program beneficiaries. The

methods of apportionment are defined as follows:

(1) *Departmental method*—(i) *Methodology.* Except as provided in paragraph (a)(1)(ii) of this section with respect to the treatment of the private room cost differential for cost reporting periods starting on or after October 1, 1982, the ratio of beneficiary charges to total patient charges for the services of each ancillary department is applied to the cost of the department; to this is added the cost of routine services for program beneficiaries, determined on the basis of a separate average cost per diem for general routine patient care areas as defined in paragraph (b) of this section, taking into account, in hospitals, a separate average cost per diem for each intensive care unit, coronary care unit, and other intensive care type inpatient hospital units.

(ii) *Exception: Indirect cost of private rooms.* For cost reporting periods starting on or after October 1, 1982, except with respect to a hospital receiving payment under part 412 of this chapter (relating to the prospective payment system), the additional cost of furnishing services in private room accommodations is apportioned to Medicare only if these accommodations are furnished to program beneficiaries, and are medically necessary. To determine routine service cost applicable to beneficiaries—

(A) Multiply the average cost per diem (as defined in paragraph (b) of this section) by the total number of Medicare patient days (including private room days whether or not medically necessary);

(B) Add the product of the average per diem private room cost differential (as defined in paragraph (b) of this section) and the number of medically necessary private room days used by beneficiaries; and

(C) Effective October 1, 1990, do not include private rooms furnished for SNF-type and NF-type services under the swing-bed provision in the number of days in paragraphs (a)(1)(ii)(A) and (B) of this section.

(2) *Carve-out out method*—(i) The carve-out out method is used to allocate hospital inpatient general routine service costs in a participating swing-bed hospital, as defined in §413.114(b). Under this method, effective for services furnished on or after October 1, 1990, the reasonable costs attributable to the inpatient routine SNF-type and NF-type services furnished to all classes of patients are subtracted from total inpatient routine service costs before computing the average cost per diem for inpatient routine hospital care.

(ii) The cost per diem attributable to the routine SNF-type services covered by Medicare is based on the regional Medicare swing-bed SNF rate in effect for a given calendar year, as described in §413.114(c). The Medicare SNF rate applies only to days covered and paid as Medicare days. When Medicare coverage runs out, the Medicare rate no longer applies.

(iii) The cost per diem attributable to all non-Medicare swing-bed days is based on the average statewide Medicaid NF rate for the prior calendar year, adjusted to approximate the average NF rate for the current calendar year.

(iv) The sum of total Medicare SNF-type days multiplied by the cost per diem attributable to Medicare SNF-type services and the total NF-type days multiplied by the cost per diem attributable to all non-Medicare days is subtracted from total inpatient general routine service costs. The cost per diem for inpatient routine hospital care is computed based on the remaining inpatient routine service costs.

(3) *Cost per visit by type-of-service method—HHAs.* For cost reporting periods beginning on or after October 1, 1980, all HHAs must use the cost per visit by type-of-service method of apportioning costs between Medicare and non-Medicare beneficiaries. Under this method, the total allowable cost of all visits for each type of service is divided by the total number of visits for that type of service. Next, for each type of service, the number of Medicare covered visits is multiplied by the average cost per visit just computed. This represents the cost Medicare will recognize as the cost for that service, subject to cost limits published by HCFA (see §413.30).

(b) *Definitions.* As used in this section—

Ancillary services means the services for which charges are customarily made in addition to routine services.

Apportionment means an allocation or distribution of allowable cost between the beneficiaries of the Medicare program and other patients.

Average cost per diem for general routine services means the following:

(1) For cost reporting periods beginning on or after October 1, 1982, subject to the provisions on swing-bed hospitals, the average cost of general routine services net of the private room cost differential. The average cost per diem is computed by the following methodology:

(i) Determine the total private room cost differential by multiplying the average per diem private room cost differential determined in paragraph (c) of this section by the total number of private room patient days.

(ii) Determine the total inpatient general routine service costs net of the total private room cost differential by subtracting the total private room cost differential from total inpatient general routine service costs.

(iii) Determine the average cost per diem by dividing the total inpatient general routine service cost net of private room cost differential by all inpatient general routine days, including total private room days.

(2) For swing-bed hospitals, the amount computed by—(i) Subtracting the routine costs associated with Medicare SNF-type days and non-Medicare NF-type days from the total allowable inpatient cost for routine services (excluding the cost of services provided in intensive care units, coronary care units, and other intensive care type inpatient hospital units and nursery costs); and

(ii) Dividing the remainder (excluding the total private room cost differential) by the total number of inpatient hospital days of care (excluding Medicare SNF-type days and non-Medicare NF-type days of care, days of care in intensive care units, coronary care units, and other intensive care type inpatient hospital units; and newborn days; but including total private room days).

Average cost per diem for hospital intensive care type units means the amount computed by dividing the total allowable costs for routine services in each of these units by the total number of inpatient days of care furnished in each of these units.

Average per diem private room cost differential means the difference in the average per diem cost of furnishing routine services in a private room and in a semi-private room. (This differential is not applicable to hospital intensive care type units.) (The method for computing this differential is described in paragraph (c) of this section.)

Charges means the regular rates for various services that are charged to both beneficiaries and other paying patients who receive the services. Implicit in the use of charges as the basis for apportionment is the objective that charges for services be related to the cost of the services.

Intensive care type inpatient hospital unit means a hospital unit that furnishes services to critically ill inpatients. Examples of intensive care type units include, but are not limited to, intensive care units, trauma units, coronary care units, pulmonary care units, and burn units. Excluded as intensive care type units are postoperative recovery rooms, postanesthesia recovery rooms, maternity labor rooms, and subintensive or intermediate care units. (The unit must also meet the criteria of paragraph (d) of this section.)

Nursing facility (NF)-type services, formerly known as ICF and SNF-type services, are routine services furnished by a swing-bed hospital to Medicaid and other non-Medicare patients. Under the Medicaid program, effective October 1, 1990, facilities are no longer certified as SNFs or ICFs but instead are certified only as NFs and can provide services as defined in section 1919(a)(1) of the Act.

Skilled nursing facility (SNF)-type services are routine services furnished by a swing-bed hospital that would constitute extended care services if furnished by an SNF. SNF-type services include routine SNF services furnished in the distinct part SNF of a hospital complex that is combined with the hospital general routine service area cost center under § 413.24(d)(5). Effective October 1, 1990, only Medicare covered

services are included in the definition of SNF-type services.

Ratio of beneficiary charges to total charges on a departmental basis means the ratio of charges to beneficiaries of the Medicare program for services of a revenue-producing department or center to the charges to all patients for that center during an accounting period. After each revenue-producing center's ratio is determined, the cost of services furnished to beneficiaries of the Medicare program is computed by applying the individual ratio for the center to the cost of the related center for the period.

Routine services means the regular room, dietary, and nursing services, minor medical and surgical supplies, and the use of equipment and facilities for which a separate charge is not customarily made.

(c) *Method for computing the average per diem private room cost differential.* Compute the average per diem private room cost differential as follows:

(1) Determine the average per diem private room charge differential by subtracting the average per diem charge for all semi-private room accommodations from the average per diem charge for all private room accommodations. The average per diem charge for private room accommodations is determined by dividing the total charges for private room accommodations by the total number of days of care furnished in private room accommodations. The average per diem charge for semi-private accommodations is determined by dividing the total charges for semi-private room accommodations by the total number of days of care furnished in semi-private accommodations.

(2) Determine the inpatient general routine cost to charge ratio by dividing total inpatient general routine service cost by the total inpatient general routine service charges.

(3) Determine the average per diem private room cost differential by multiplying the average per diem private room charge differential determined in paragraph (c)(1) of this section by the ratio determined in paragraph (c)(2) of this section.

(d) *Criteria for identifying intensive care type units.* For purposes of determining costs under this section, a unit will be identified as an intensive care type inpatient hospital unit only if the unit—

(1) Is in a hospital;

(2) Is physically and identifiably separate from general routine patient care areas, including subintensive or intermediate care units, and ancillary service areas. There cannot be a concurrent sharing f nursing staff between an intensive care type unit and units or areas furnishing different levels or types of care. However, two or more intensive care type units that concurrently share nursing staff can be reimbursed as one combined intensive care type unit if all other criteria are met. Float nurses (nurses who work in different units on an as-needed basis) can be utilized in the intensive care type unit. If a float nurse works in two different units during the same eight hour shift, then the costs must be allocated to the appropriate units depending upon the time spent in those units. The hospital must maintain adequate records to support the allocation. If such records are not available, then the costs must be allocated to the general routine services cost areas;

(3) Has specific written policies that include criteria for admission to, and discharge from, the unit;

(4) Has registered nursing care available on a continuous 24-hour basis with at least one registered nurse present in the unit at all times;

(5) Maintains a minimum nurse-patient ratio of one nurse to two patients per patient day. Included in the calculation of this nurse-patient ratio are registered nurses, licensed vocational nurses, licensed practical nurses, and nursing assistants who provide patient care. Not included are general support personnel such as ward clerks, custodians, and housekeeping personnel; and

(6) Is equipped, or has available for immediate use, life-saving equipment necessary to treat the critically ill patients for which it is designed. This equipment may include, but is not limited to, respiratory and cardiac monitoring equipment, respirators, cardiac defibrillators, and wall or canister oxygen and compressed air.

(e) *Application*—(1) *Departmental method; Cost reporting periods beginning on or after October 1, 1982.*

(i) The following example illustrates how costs would be determined, using only inpatient data, for cost reporting periods beginning on or after October 1, 1982, based on apportionment of—

(A) The average cost per diem for general routine services (subject to the private room differential provisions of paragraph (a)(1)(iii) of this section);

(B) The average cost per diem for each intensive care type unit;

(C) The ratio of beneficiary charges to total charges applied to cost by department.

HOSPITAL Y

Department	Charges to program beneficiaries	Total charges	Ratio of beneficiary charges to total charges	Total cost	Cost of beneficiary services
	Percent				
Operating rooms	$20,000	$70,000	28⅔	$77,000	$22,000
Delivery rooms	0	12,000	0	30,000	0
Pharmacy	20,000	60,000	33⅓	45,000	15,000
X-ray	24,000	100,000	24	75,000	18,000
Laboratory	40,000	140,000	28⅔	98,000	28,000
Others	6,000	30,000	20	25,000	5,000
Total	110,000	412,000	.....	350,000	88,000

	Total inpatient days	Total cost	Average cost per diem	Program in patient days	Cost of beneficiary services
General routine	30,000	$630,000	$21	8,000	$168,000
Coronary care unit	500	20,000	40	200	8,000
Intensive care unit	3,000	108,000	36	1,000	36,000
	33,500	758,000	.....	9,200	212,000
Total	.....	.....	.....	.....	300,000

(ii) The following illustrates how apportionment based on an average cost per diem for general routine services is determined.

HOSPITAL E

Facts	Private accommodations	Semi-private accommodations	Total
Total charges	$20,000	$175,000	$195,000
Total days	100	1,000	1,100
Programs days	70	400	470
Medically necessary for program beneficiaries	20	.....	20
Total general routine service costs	.....	.....	165,000
Average private room per diem charge ($20,000 private room charges ÷ 100 days)			[1] $200
Average semi-private room per diem charge ($175,000 semi-private charge ÷ 1,000 days)			[1] $175

[1] Per diem.

Average per diem private room cost differential.

1. Average per diem private room charge differential ($200 private room per diem—$175, semi-private room per diem), $25.
2. Inpatient general routine cost/charge ratio ($165,000 total costs ÷ $195,000 total charges), 0.8461538.
3. Average per diem private room cost differential ($25 charge differential × .8461538 cost/charge ratio), $21.15.

Average cost per diem for inpatient general routine services.

4. Total private room cost differential ($21.15 average per diem cost differential × 100 private room days), $2,115.
5. Total inpatient general routine service costs net of private room cost differential ($165,000 total routine cost −$2,115 private room cost differential), $162,885.
6. Average cost per diem for inpatient general routine services ($162,885 routine cost net of private room cost differential ÷ 1,100 patient days), $148.08.

Medicare general routine service cost.

7. Total routine per diem cost applicable to Medicare ($148.08 average cost per diem × 470 Medicare private and semi-private patient days), $69,598.
8. Total private room cost differential applicable to Medicare ($21.15 average per diem private room cost differential × 20 medically necessary private room days), $423.

9. Medicare inpatient general routine service cost ($423 Medicare private room cost differential + $69,598 Medicare cost of general routine inpatient services), $70,021.

(2) *Carve out method.* The following illustrates how apportionment is determined in a hospital reimbursed under the carve out method (subject to the private room differential provisions of paragraph (a)(1)(ii) of this section):

HOSPITAL K

[Determination of cost of routine SNF-type and ICF-type services and general routine hospital services[1]]

Facts	Days of care		
	General routine hospital	SNF-type	ICF-type
Total days of care	2,000	400	100
Medicare days of care ...	600	300	.....
Average Medicaid rate ..	N/A	$35	$20

Total inpatient general routine service costs: $250,000

Calculation of cost of routine SNF-type services applicable to Medicare:
$35 × 300 = $10,500
Calculation of cost of general routine hospital services:
Cost of SNF-type services: $35 × 400 ..... $14,000
Cost of ICF-type services: $20 × 100 2,000
Total $16,000
Average cost per diem of general routine hospital services:
$250,000 — $16,000 ÷ 2,000 days = $117
Medicare general routine hospital cost:
$117 × 600 = $70,200
Total Medicare reasonable cost for general routine inpatient days:
$10,500 + $70,200 = $80,700

[51 FR 34793, Sept. 30, 1986, as amended at 59 FR 45401, Sept. 1, 1994; 61 FR 51616, Oct. 3, 1996; 61 FR 58631, Nov. 18, 1996]

§ 413.56 [Reserved]

Subpart E—Payments to Providers

§ 413.60 Payments to providers: General.

(a) The fiscal intermediaries will establish a basis for interim payments to each provider. This may be done by one of several methods. If an intermediary is already paying the provider on a cost basis, the intermediary may adjust its rate of payment to an estimate of the result under the Medicare principles of reimbursement. If no organization is paying the provider on a cost basis, the intermediary may obtain the previous year's financial statement from the provider and, by applying the principles of reimbursement, compute or approximate an appropriate rate of payment. The interim payment may be related to the last year's average per diem, or to charges, or to any other ready basis of approximating costs.

(b) At the end of the period, the actual apportionment, based on the cost finding and apportionment methods selected by the provider, determines the Medicare reimbursement for the actual services provided to beneficiaries during the period.

(c) Basically, therefore, interim payments to providers will be made for services throughout the year, with final settlement on a retroactive basis at the end of the accounting period. Interim payments will be made as often as possible and in no event less frequently than once a month. The retroactive payments will take fully into account the costs that were actually incurred and settle on an actual, rather than on an estimated basis.

§ 413.64 Payments to providers: Specific rules.

(a) *Reimbursement on a reasonable cost basis.* Providers of services paid on the basis of the reasonable cost of services furnished to beneficiaries will receive interim payments approximating the actual costs of the provider. These payments will be made on the most expeditious schedule administratively feasible but not less often than monthly. A retroactive adjustment based on actual costs will be made at the end of a reporting period.

(b) *Amount and frequency of payment.* Medicare states that providers of services will be paid the reasonable cost of services furnished to beneficiaries. Since actual costs of services cannot be determined until the end of the accounting period, the providers must be paid on an estimated cost basis during the year. While Medicare provides that interim payments will be made no less often than monthly, intermediaries are expected to make payments on the most expeditious basis administratively feasible. Whatever estimated

cost basis is used for determining interim payments during the year, the intent is that the interim payments shall approximate actual costs as nearly as is practicable so that the retroactive adjustment based on actual costs will be as small as possible.

(c) *Interim payments during initial reporting period.* At the beginning of the program or when a provider first participates in the program, it will be necessary to establish interim rates of payment to providers of services. Once a provider has filed a cost report under the Medicare program, the cost report may be used as a basis for determining the interim rate of reimbursement for the following period. However, since initially there is no previous history of cost under the program, the interim rate of payment must be determined by other methods, including the following:

(1) If the intermediary is already paying the provider on a cost or cost-related basis, the intermediary will adjust its rate of payment to the program's principles of reimbursement. This rate may be either an amount per inpatient day, or a percent of the provider's charges for services furnished to the program's beneficiaries.

(2) If an organization other than the intermediary is paying the provider for services on a cost or cost-related basis, the intermediary may obtain from that organization or from the provider itself the rate of payment being used and other cost information as may be needed to adjust that rate of payment to give recognition to the program's principles of reimbursement.

(3) It no organization is paying the provider on a cost or cost-related basis, the intermediary will obtain the previous year's financial statement from the provider. By analysis of such statement in light of the principles of reimbursement, the intermediary will compute an appropriate rate of payment.

(4) After the initial interim rate has been set, the provider may at any time request, and be allowed, an appropriate increase in the computed rate, upon presentation of satisfactory evidence to the intermediary that costs have increased. Likewise, the intermediary may adjust the interim rate of payment if it has evidence that actual costs may fall significantly below the computed rate.

(d) *Interim payments for new providers.* (1) Newly-established providers will not have cost experience on which to base a determination of an interim rate of payment. In such cases, the intermediary will use the following methods to determine an appropriate rate:

(i) If there is a provider or providers comparable in substantially all relevant factors to the provider for which the rate is needed, the intermediary will base an interim rate of payment on the costs of the comparable provider.

(ii) If there are no substantially comparable providers from whom data are available, the intermediary will determine an interim rate of payment based on the budgeted or projected costs of the provider.

(2) Under either method, the intermediary will review the provider's cost experience after a period of three months. If need for an adjustment is indicated, the interim rate of payment will be adjusted in line with the provider's cost experience.

(e) *Interim payments after initial reporting period.* Interim rates of payment for services provided after the initial reporting period will be established on the basis of the cost report filed for the previous year covering Medicare services. The current rate will be determined—whether on a per diem or percentage of charges basis—using the previous year's costs of covered services and making any appropriate adjustments required to bring, as closely as possible, the current year's rate of interim payment into agreement with current year's costs. This interim rate of payment may be adjusted by the intermediary during an accounting period if the provider submits appropriate evidence that its actual costs are or will be significantly higher than the computed rate. Likewise, the intermediary may adjust the interim rate of payment if it has evidence that actual costs may fall significantly below the computed rate.

(f) *Retroactive adjustment.* (1) Medicare provides that providers of services will be paid amounts determined to be due, but not less often than monthly,

with necessary adjustments due to previously made overpayments or underpayments. Interim payments are made on the basis of estimated costs. Actual costs reimbursable to a provider cannot be determined until the cost reports are filed and costs are verified. Therefore, a retroactive adjustment will be made at the end of the reporting period to bring the interim payments made to the provider during the period into agreement with the reimbursable amount payable to the provider for the services furnished to program beneficiaries during that period.

(2) In order to reimburse the provider as quickly as possible, an initial retroactive adjustment will be made as soon as the cost report is received. For this purpose, the costs will be accepted as reported, unless there are obvious errors or inconsistencies, subject to later audit. When an audit is made and the final liability of the program is determined, a final adjustment will be made.

(3) To determine the retroactive adjustment, the amount of the provider's total allowable cost apportioned to the program for the reporting year is computed. This is the total amount of reimbursement the provider is due to receive from the program and the beneficiaries for covered services furnished during the reporting period. The total of the interim payments made by the program in the reporting year and the deductibles and coinsurance amounts receivable from beneficiaries is computed. The difference between the reimbursement due and the payments made is the amount of the retroactive adjustment.

(g) *Accelerated payments to providers.* Upon request, an accelerated payment may be made to a provider of services that is not receiving periodic interim payments under paragraph (h) of this section if the provider has experienced financial difficulties due to a delay by the intermediary in making payments or in exceptional situations, in which the provider has experienced a temporary delay in preparing and submitting bills to the intermediary beyond its normal billing cycle. Any such payment must be approved first by the intermediary and then by HCFA. The amount of the payment is computed as a percentage of the net reimbursement for unbilled or unpaid covered services. Recovery of the accelerated payment may be made by recoupment as provider bills are processed or by direct payment.

(h) *Periodic interim payment method of reimbursement*—(1) *Covered services furnished before July 1, 1987.* In addition to the regular methods of interim payment on individual provider billings for covered services, the periodic interim payment (PIP) method is available for Part A hospital and SNF inpatient services and for both Part A and Part B HHA services.

(2) *Covered services furnished on or after July 1, 1987.* Effective with claims received on or after July 1, 1987, the periodic interim payment (PIP) method is available for the following:

(i) Part A inpatient hospital services furnished in hospitals that are excluded from the prospective payment systems under subpart B of part 412 of this chapter.

(ii) Part A services furnished in hospitals receiving payment in accordance with a demonstration project authorized under section 402(a) of Public Law 90–248 (42 U.S.C. 1395b–1) or section 222(a) of Public Law 92–603 (42 U.S.C. 1395b–1 (note)), or a State reimbursement control system approved under section 1886(c) of the Act and subpart C of part 403 of this chapter, if that type of payment is specifically approved by HCFA as an integral part of the demonstration or control system. If that type of payment is not an integral part of the demonstration or control system, PIP is available for the hospital under paragraph (h)(1)(i) of this section for hospitals excluded from the prospective payment systems or under §412.116(b) of this chapter for prospective payment hospitals.

(iii) Part A SNF services furnished in cost reporting periods beginning before July 1, 1998. (For services furnished in subsequent cost reporting periods, see §413.350 regarding periodic interim payments for skilled nursing facilities).

(iv) Part A and Part B HHA services.

(v) Part A services furnished in hospitals paid under the prospective payment system, including distinct part psychiatric or rehabilitation units, as described in §412.116(b) of this chapter.

(vi) Services furnished in a hospice as specified in part 418 of this chapter. Payment on a PIP basis is described in § 418.307 of this chapter.

(3) Any participating provider furnishing the services described in paragraph (h)(1) of this section that establishes to the satisfaction of the intermediary that it meets the following requirements may elect to be reimbursed under the PIP method, beginning with the first month after its request that the intermediary finds administratively feasible:

(i) The provider's estimated total Medicare reimbursement for inpatient services is at least $25,000 a year computed under the PIP formula or, in the case of an HHA, either its estimated—

(A) Total Medicare reimbursement for Part A and Part B services is at least $25,000 a year computed under the PIP formula; or

(B) Medicare reimbursement computed under the PIP formula is at least 50 percent of estimated total allowable cost.

(ii) The provider has filed at least one completed Medicare cost report accepted by the intermediary as providing an accurate basis for computation of program payment (except in the case of a provider requesting reimbursement under the PIP method upon first entering the Medicare program).

(iii) The provider has the continuing capability of maintaining in its records the cost, charge, and statistical data needed to accurately complete a Medicare cost report on a timely basis.

(iv) The provider has repaid or agrees to repay any outstanding current financing payment in full, such payment to be made before the effective date of its requested conversion from a regular interim payment method to the PIP method.

(4) No conversion to the PIP method may be made with respect to any provider until after that provider has repaid in full its outstanding current financing payment.

(5) The intermediary's approval of a provider's request for reimbursement under the PIP method will be conditioned upon the intermediary's best judgment as to whether payment can be made to the provider under the PIP method without undue risk of its resulting in an overpayment because of greatly varying or substantially declining Medicare utilization, inadequate billing practices, or other circumstances. The intermediary may terminate PIP reimbursement to a provider at any time it determines that the provider no longer meets the qualifying requirements or that the provider's experience under the PIP method shows that proper payment cannot be made under this method.

(6) Payment will be made biweekly under the PIP method unless the provider requests a longer fixed interval (not to exceed one month) between payments. The payment amount will be computed by the intermediary to approximate, on the average, the cost of covered inpatient or home health services furnished by the provider during the period for which the payment is to be made, and each payment will be made two weeks after the end of such period of services. Upon request, the intermediary will, if feasible, compute the provider's payments to recognize significant seasonal variation in Medicare utilization of services on a quarterly basis starting with the beginning of the provider's reporting year.

(7) A provider's PIP amount may be appropriately adjusted at any time if the provider presents or the intermediary otherwise obtains evidence relating to the provider's costs or Medicare utilization that warrants such adjustment. In addition, the intermediary will recompute the payment immediately upon completion of the desk review of a provider's cost report and also at regular intervals not less often than quarterly. The intermediary may make a retroactive lump sum interim payment to a provider, based upon an increase in its PIP amount, in order to bring past interim payments for the provider's current cost reporting period into line with the adjusted payment amount. The objective of intermediary monitoring of provider costs and utilization is to assure payments approximating, as closely as possible, the reimbursement to be determined at settlement for the cost reporting period. A significant factor in evaluating the amount of the payment in terms of the realization of the projected Medicare utilization of services

is the timely submittal to the intermediary of completed admission and billing forms. All providers must complete billings in detail under this method as under regular interim payment procedures.

(i) *Bankruptcy or insolvency of provider.* If on the basis of reliable evidence, the intermediary has a valid basis for believing that, with respect to a provider, proceedings have been or will shortly be instituted in a State or Federal court for purposes of determining whether such provider is insolvent or bankrupt under an appropriate State or Federal law, any payments to the provider will be adjusted by the intermediary, notwithstanding any other regulation or program instruction regarding the timing or manner of such adjustments, to a level necessary to insure that no overpayment to the provider is made.

(j) *Interest payments resulting from judicial review*—(1) *Application.* If a provider of services seeks judicial review by a Federal court (see §405.1877 of this chapter) of a decision furnished by the Provider Reimbursement Review Board or subsequent reversal, affirmation, or modification by the Secretary, the amount of any award of such Federal court will be increased by interest payable by the party against whom the judgment is made (see §413.153 for treatment of interest). The interest is payable for the period beginning on the first day of the first month following the 180-day period which began on either the date the intermediary made a final determination or the date the intermediary would have made a final determination had it been done on a timely basis (see §§405.1835(b) and 405.1841(a) of this chapter).

(2) *Amount due.* Section 1878(f) of the Act, 42 U.S.C. 1395oo(f), authorizes a court to award interest in favor of the prevailing party on any amount due as a result of the court's decision. If the intermediary withheld any portion of the amount in controversy prior to the date the provider seeks judicial review by a Federal court, and the Medicare program is the prevailing party, interest is payable by the provider only on the amount not withheld. Similarly, if the Medicare program seeks to recover amounts previously paid to a provider, and the provider is the prevailing party, interest on the amounts previously paid to a provider is not payable by the Medicare program since that amount had been paid and is not due the provider.

(3) *Rate.* The amount of interest to be paid is equal to the rate of return on equity capital (see §413.157) in effect for the month in which the civil action is commenced.

Example: An intermediary made a final determinaton on the amount of Medicare program reimbursement on June 15, 1974, and the provider appealed that determination to the Provider Reimbursement Review Board. The Board heard the appeal and rendered a decision adverse to the provider. On October 28, 1974, the provider commenced civil action to have such decision reviewed. The rate of return on equity capital for the month of October 1974 was 11.625 percent. The period for which interest is computed begins on January 1, 1975, and the interest beginning January 1, 1975, would be at the rate of 11.625 percent per annum.

[51 FR 34793, Sept. 30, 1986, as amended at 51 FR 42238, Nov. 24, 1986; 53 FR 1628, Jan. 21, 1988; 57 FR 39830, Sept. 1, 1992; 59 FR 36713, July 19, 1994; 64 FR 41682, July 30, 1999]

§ 413.70 Payment for services of a CAH.

(a) Except as provided in paragraph (b) of this section, payment for inpatient and outpatient services of a CAH is the reasonable costs of the CAH in providing such services, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in this part and in part 415 of this chapter.

(b) The following payment principles are excluded when determining payment for CAH inpatient and outpatient services:

(1) For inpatient services—

(i) Lesser of cost or charges;

(ii) Ceilings on hospital operating costs; and

(iii) Reasonable compensation equivalent (RCE) limits for physician services to providers;

(2) For outpatient services—

(i) Lesser of costs or charges;

(ii) RCE limits;

(iii) Any type of reduction to operating or capital costs under §413.124 or §413.130(j)(7) of this part;

(iv) Blended payment amounts for ASC, radiology, and other diagnostic services; and

(v) Clinical laboratory fee schedule.

[63 FR 26358, May 12, 1998]

§ 413.74 Payment to a foreign hospital.

(a) *Principle.* Section 1814(f) of the Act provides for the payment of emergency and nonemergency inpatient hospital services furnished by foreign hospitals to Medicare beneficiaries. Subpart H of part 424 of this chapter, together with this section, specify the conditions for payment. These conditions may result in payments only to Canadian and Mexican hospitals.

(b) *Amount of payment.* Effective with admissions on or after January 1, 1980, the reasonable cost for services covered under the Medicare program furnished to beneficiaries by a foreign hospital will be equal to 100 percent of the hospital's customary charges (as defined in § 413.13(b)) for the services.

(c) *Submittal of claims.* The hospital must establish its customary charges for the services by submitting an itemized bill with each claim it files in accordance with its election under § 424.104 of this chapter.

(d) *Exchange rate.* Payment to the hospital will be subject to the official exchange rate on the date the patient is discharged and to the applicable deductible and coinsurance amounts described in §§ 409.80 through 409.83.

[51 FR 34793, Sept. 30, 1986, as amended at 51 FR 41351, Nov. 14, 1986; 53 FR 6648, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988]

Subpart F—Specific Categories of Costs

§ 413.80 Bad debts, charity, and courtesy allowances.

(a) *Principle.* Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable cost; however, except for anesthetists' services described under paragraph (h) of this section, bad debts attributable to the deductibles and coinsurance amounts are reimbursable under the program.

(b) *Definitions*—(1) *Bad debts.* Bad debts are amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. ''Accounts receivable'' and ''notes receivable'' are designations for claims arising from the furnishing of services, and are collectible in money in the relatively near future.

(2) *Charity allowances.* Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient. Cost of free care (uncompensated services) furnished under a Hill-Burton obligation are considered as charity allowances.

(3) *Courtesy allowances.* Courtesy allowances indicate a reduction in charges in the form of an allowance to physicians, clergy, members of religious orders, and others as approved by the governing body of the provider, for services received from the provider. Employee fringe benefits, such as hospitalization and personnel health programs, are not considered to be courtesy allowances.

(c) *Normal accounting treatment: Reduction in revenue.* Bad debts, charity, and courtesy allowances represent reductions in revenue. The failure to collect charges for services furnished does not add to the cost of providing the services. Such costs have already been incurred in the production of the services.

(d) *Requirements for Medicare.* Under Medicare, costs of covered services furnished beneficiaries are not to be borne by individuals not covered by the Medicare program, and conversely, costs of services provided for other than beneficiaries are not to be borne by the Medicare program. Uncollected revenue related to services furnished to beneficiaries of the program generally means the provider has not recovered the cost of services covered by that revenue. The failure of beneficiaries to pay the deductible and coinsurance amounts could result in the related costs of covered services being borne by other than Medicare beneficiaries. To assure that such covered service costs are not borne by others, the costs attributable to the deductible and coinsurance amounts that remain unpaid are added to the Medicare share of allowable costs. Bad debts arising from other sources are not allowable costs.

(e) *Criteria for allowable bad debt.* A bad debt must meet the following criteria to be allowable:

(1) The debt must be related to covered services and derived from deductible and coinsurance amounts.

(2) The provider must be able to establish that reasonable collection efforts were made.

(3) The debt was actually uncollectible when claimed as worthless.

(4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

(f) *Charging of bad debts and bad debt recoveries.* The amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In some cases an amount previously written off as a bad debt and allocated to the program may be recovered in a subsequent accounting period; in such cases the income therefrom must be used to reduce the cost of beneficiary services for the period in which the collection is made.

(g) *Charity allowances.* Charity allowances have no relationship to beneficiaries of the Medicare program and are not allowable costs. These charity allowances include the costs of uncompensated services furnished under a Hill-Burton obligation. (Note: In accordance with section 106(b) of Pub. L. 97–248 (enacted September 3, 1982), this sentence is effective with respect to any costs incurred under Medicare except that it does not apply to costs which have been allowed prior to September 3, 1982, pursuant to a final court order affirmed by a United States Court of Appeals.) The cost to the provider of employee fringe-benefit programs is an allowable element of reimbursement.

(h) *Limitations on bad debts.* In determining reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs (as defined in paragraph (e) of this section) is reduced—

(1) For cost reporting periods beginning during fiscal year 1998, by 25 percent;

(2) For cost reporting periods beginning during fiscal year 1999, by 40 percent; and

(3) For cost reporting periods beginning during a subsequent fiscal year, by 45 percent.

(i) *Exception.* Bad debts arising from services for anesthetists paid under a fee schedule are not reimbursable under the program.

[51 FR 34793, Sept. 30, 1986, as amended at 57 FR 33898, July 31, 1992; 60 FR 63189, Dec. 8, 1995; 63 FR 41005, July 31, 1998]

§ 413.85 Cost of educational activities.

(a) *Payment*—(1) *General rule.* Except as provided in paragraph (a)(2) of this section, a provider's allowable cost may include its net cost of approved educational activities, as calculated under paragraph (g) of this section. The net cost is subject to apportionment based on Medicare utilization as described in § 413.50.

(2) *Exception.* For cost reporting periods beginning on or after July 1, 1985, payment to hospitals and hospital-based providers for approved residency programs in medicine, osteopathy, dentistry, and podiatry is determined as provided in § 413.86.

(b) *Definition—Approved educational activities.* Approved educational activities means formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution. These activities must be licensed if required by State law. If licensing is not required, the institution must receive approval from the recognized national professional organization for the particular activity.

(c) *Educational activities.* Many providers engage in educational activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the community's needs for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these

costs, the program will participate appropriately in the support of these activities. Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

(d) *Activities not within the scope of this principle.* The costs of the following activities are not within the scope of this principle but are recognized as normal operating costs and are reimbursed in accordance with applicable principles—

(1) Orientation and on-the-job training;

(2) Part-time education for bona fide employees at properly accredited academic or technical institutions (including other providers) devoted to undergraduate or graduate work;

(3) Costs, including associated travel expense, or sending employees to educational seminars and workshops that increase the quality of medical care or operating efficiency of the provider;

(4) Maintenance of a medical library;

(5) Training of a patient or patient's family in the use of medical appliances;

(6) Clinical training of students not enrolled in an approved education program operated by the provider; and

(7) Other activities that do not involve the actual operation of an approved education program including the costs of interns and residents in anesthesiology who are employed to replace anesthetists.

(e) *Approved programs.* Recognized professional and paramedical educational training programs now being conducted by provider institutions, and their approving bodies, include the following:

(1) Cyto-technology.	Committee on Allied Health, Education, and Accreditation in collaboration with the Board of Schools of Medical Technology, American Society of Clinical Pathologists.
(2) Dietetic internships.	The American Dietetic Association.
(3) Hospital administration residencies.	Accrediting Commission on Education in Health Services Administration.
(4) Inhalation therapy.	Committee on Allied Health, Education, and Accreditation in collaboration with the Board of Schools of Inhalation Therapy.
(5) Medical records.	Committee on Allied Health, Education, and Accreditation in collaboration with the Committee on Education and Registration of the American Association of Medical Records Librarians.
(6) Medical technology.	Committee on Allied Health, Education, and Accreditation in collaboration with the Board of Schools of Medical Technology, American Society of Clinical Pathologists.
(7) Nurse anesthetists.	The American Association of Nurse Anesthetists.
(8) Professional nursing.	Approved by the respective State approving authorities. Reported for the United States by the National League for Nursing.
(9) Practical nursing.	Approved by the respective State approving authorities. Reported for the United States by the National League for Nursing.
(10) Occupational Therapy.	Committee on Allied Health, Education, and Accreditation in collaboration with the Council on Education of the American Occupational Therapy Association.
(11) Pharmacy residencies.	American Society of Hospital Pharmacists.
(12) Physical therapy.	Committee on Allied Health, Education, and Accreditation in collaboration with the American Physical Therapy Association.
(13) X-ray technology.	Committee on Allied Health, Education, and Accreditation in collaboration with the American College of Radiology.

(f) *Other educational programs.* There may also be other educational programs not included in the foregoing in which a provider institution is engaged. Appropriate consideration will be given by the intermediary and HCFA to the costs incurred for those activities that come within the purview of the principle when determining the allowable costs for apportionment under the Medicare program.

(g) *Calculating net cost.* Net costs of approved educational activities are determined by deducting, from a provider's total costs of these activities, revenues it receives from tuition. For this purpose, a provider's total costs include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles in § 413.24.

(h) *Medicare+Choice organizations.* (1) Effective January 1, 1999, Medicare+Choice organizations may receive direct graduate medical education payments for the time that residents spend in nonhospital provider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs.

(2) Medicare+Choice organizations may receive direct graduate medical education payments if all of the following conditions are met:

(i) The resident spends his or her time in patient care activities.

(ii) The Medicare+Choice organization incurs ''all or substantially all'' of the costs for the training program in the nonhospital setting as defined in § 413.86(b).

(iii) There is a written agreement between the Medicare+Choice organization and the nonhospital site that indicates the Medicare+Choice organization will incur the costs of the resident's salary and fringe benefits and provide reasonable compensation to the nonhospital site for teaching activities.

(3) A Medicare+Choice organization's allowable direct graduate medical education costs, subject to the redistribution and community support principles in § 413.85(c), consist of—

(i) Residents' salaries and fringe benefits (including travel and lodging where applicable); and

(ii) Reasonable compensation to the nonhospital site for teaching activities related to the training of medical residents.

(4) The direct graduate medical education payment is equal to the product of—

(i) The lower of—

(A) The Medicare+Choice organization's allowable direct graduate medical education costs per resident as defined in paragraph (h)(3) of this section; or

(B) The national average per resident amount; and

(ii) Medicare's share, which is equal to the ratio of the number of Medicare beneficiaries enrolled to the total number of individuals enrolled in the Medicare+Choice organization.

(5) Direct graduate medical education payments made to Medicare+Choice organizations under this section are made from the Federal Supplementary Medical Insurance Trust Fund.

[51 FR 34793, Sept. 30, 1986, as amended at 54 FR 40315, Sept. 29, 1989; 63 FR 41005, July 31, 1998]

§ 413.86 Direct graduate medical education payments.

(a) *Statutory basis and scope*—(1) *Basis.* This section implements section 1886(h) of the Act by establishing the methodology for Medicare payment of the cost of direct graduate medical educational activities.

(2) *Scope.* This section applies to Medicare payments to hospitals and hospital-based providers for the costs of approved residency programs in medicine, osteopathy, dentistry, and podiatry for cost reporting periods beginning on or after July 1, 1985.

(b) *Definitions.* For purposes of this section, the following definitions apply:

Affiliated group means—

(1) Two or more hospitals located in the same urban or rural area (as those terms are defined in § 412.62(f) of this subchapter) or in contiguous areas if individual residents work at each of the hospitals during the course of the program; or

(2) If the hospitals are not located in the same or a contiguous urban or

rural area, the hospitals are jointly listed—

(i) As the sponsor, primary clinical site or major participating institution for one or more of the programs as these terms are used in *Graduate Medical Education Directory, 1997–1998;* or

(ii) As the sponsor or under ''affiliations and outside rotations'' for one or more programs in operation in *Opportunities, Directory of Osteopathic Postdoctoral Education Programs.*

(3) The hospitals are under common ownership.

All or substantially all of the costs for the training program in the nonhospital setting means the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education.

Approved geriatric program means a fellowship program of one or more years in length that is approved by one of the national organizations listed in § 415.152 of this chapter under that respective organization's criteria for geriatric fellowship programs.

Approved medical residency program means a program that meets one of the following criteria:

(1) Is approved by one of the national organizations listed in § 415.152 of this chapter.

(2) May count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications:

(i) The Directory of Graduate Medical Education Programs published by the American Medical Association, and available from American Medical Association, Department of Directories and Publications, 515 North State Street, Chicago, Illinois 60610; or

(ii) The Annual Report and Reference Handbook published by the American Board of Medical Specialties, and available from American Board of Medical Specialties, One Rotary Center, suite 805, Evanston, Illinois 60201.

(3) Is approved by the Accreditation Council For Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine.

(4) Is a program that would be accredited except for the accrediting agency's reliance upon an accreditation standard that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether the standard provides exceptions or exemptions.

Base period means a cost reporting period that began on or after October 1, 1983 but before October 1, 1984.

CPI—U stands for the Consumer Price Index for All Urban Consumers as compiled by the Bureau of Labor Statistics.

Foreign medical graduate means a resident who is not a graduate of a medical, osteopathy, dental, or podiatry school, respectively, accredited or approved as meeting the standards necessary for accreditation by one of the following organizations:

(1) The Liaison Committee on Medical Education of the American Medical Association.

(2) The American Osteopathic Association.

(3) The Commission on Dental Accreditation.

(4) The Council on Podiatric Medical Education.

FMGEMS stands for the Foreign Medical Graduate Examination in the Medical Sciences (Part I and Part II).

FTE stands for full-time equivalent.

Medicare patient load means, with respect to a hospital's cost reporting period, the total number of hospital inpatient days during the cost reporting period that are attributable to patients for whom payment is made under Medicare Part A divided by total hospital inpatient days. In calculating inpatient days, inpatient days in any distinct part of the hospital furnishing a hospital level of care are included and nursery days are excluded.

Primary care resident is a resident enrolled in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine or osteopathic general practice.

Resident means an intern, resident, or fellow who participates in an approved medical residency program, including programs in osteopathy, dentistry, and

podiatry, as required in order to become certified by the appropriate specialty board.

(c) *Payment for graduate medical education costs—General rule.* Beginning with cost reporting periods starting on or after July 1, 1985, hospitals, including hospital-based providers, are paid for the costs of approved graduate medical education programs as described in paragraph (d) through (h) of this section.

(d) *Calculating payment for graduate medical education costs.* A hospital's Medicare payment for the costs of an approved residency program is calculated as follows:

(1) *Step one.* The hospital's updated per resident amount (as determined under paragraph (e) of this section) is multipled by the actual number of FTE residents (as determined under paragraph (g) of this section). This result is the aggregate approved amount for the cost reporting period.

(2) *Step two.* The product derived in step one is multipled by the hospital's Medicare patient load.

(3) *Step three.* For portions of cost reporting periods beginning on or after January 1, 1998, the product derived in step one is multiplied by the proportion of the hospital's inpatient days attributable to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 of the Act and who are entitled to Medicare Part A or with a Medicare+Choice organization under Title XVIII, Part C of the Act. This amount is multiplied by an applicable payment percentage equal to—

(i) 20 percent for 1998;

(ii) 40 percent for 1999;

(iii) 60 percent in 2000;

(iv) 80 percent in 2001; and

(v) 100 percent in 2002 and subsequent years.

(4) *Step four.* Add the results of steps 2 and 3.

(5) *Step five.* The product derived in step two is apportioned between Part A and Part B of Medicare based on the ratio of Medicare's share of reasonable costs excluding graduate medical education costs attributable to each part as determined through the Medicare cost report.

(e) *Determining per resident amounts for the base period*—(1) *For the base period.* (i) Except as provided in paragraph (e)(4) of this section, the intermediary determines a base-period per resident amount for each hospital as follows:

(A) Determine the allowable graduate medical education costs for the cost reporting period beginning on or after October 1, 1983 but before October 1, 1984. In determining these costs, graduate medical education costs allocated to the nursery cost center, research and other nonreimbursable cost centers, and hospital-based providers that are not participating in Medicare are excluded and graduate medical education costs allocated to distinct-part hospital units and hospital-based providers that participate in Medicare are included.

(B) Divide the costs calculated in paragraph (e)(1)(i)(A) of this section by the average number of FTE residents working in all areas of the hospital complex (including those areas whose costs were excluded under paragraph (e)(1)(i)(A) of this section) for its cost reporting period beginning on or after October 1, 1983 but before October 1, 1984.

(ii) In determining the base-period per resident amount under paragraph (e)(1)(i) of this section, the intermediary—

(A) Verifies the hospital's base-period graduate medical education costs and the hospital's average number of FTE residents;

(B) Excludes from the base-period graduate medical education costs any nonallowable or misclassified costs, including those previously allowed under §412.113(b)(3) of this chapter; and

(C) Upon a hospital's request, includes graduate medical education costs that were misclassified as operating costs during the hospital's prospective payment base year and were not allowable under §412.113(b)(3) of this chapter during the graduate medical education base period. These costs may be included only if the hospital requests an adjustment of its prospective payment hospital-specific rate or target amount as described in paragraph (k)(1) of this section.

(iii) If the hospital's cost report for its GME base period is no longer subject to reopening under § 405.1885 of this chapter, the intermediary may modify the hospital's base-period costs solely for purposes of computing the per resident amount.

(iv) If the intermediary modifies a hospital's base-period graduate medical education costs as described in paragraph (e)(1)(ii)(B) of this section, the hospital may request an adjustment of its prospective payment hospital-specific rate or target amount as described in paragraph (k)(1) of this section.

(v) The intermediary notifies each hospital that either had direct graduate medical education costs or received indirect education payment in its cost reporting period beginning on or after October 1, 1984 and before October 1, 1985 of its base-period average per resident amount. A hospital may appeal this amount within 180 days of the date of that notice.

(2) *For cost reporting periods beginning on or after July 1, 1985 and before July 1, 1986.* For cost reporting periods beginning on or after July 1, 1985 and before July 1, 1986, a hospital's base-period per resident amount is adjusted as follows:

(i) If a hospital's base period began on or after October 1, 1983 and before July 1, 1984, the amount is adjusted by the percentage change in the CPI–U that occurred between the hospital's base period and the first cost reporting period to which the provisions of this section apply. The adjusted amount is then increased by one percent.

(ii) If a hospital's base period began on or after July 1, 1984 and before October 1, 1984, the amount is increased by one percent.

(3) *For cost reporting periods beginning on or after July 1, 1986.* For cost reporting periods beginning on or after July 1, 1986, a hospital's base-period per resident amount is adjusted as follows:

(i) Except as provided in paragraph (e)(3)(ii) of this section, each hospital's per resident amount for the previous cost reporting is adjusted by the projected change in the CPI-U for the 12-month cost reporting period. This adjustment is subject to revision during the settlement of the cost report to reflect actual changes in the CPI-U that occurred during the cost reporting period.

(ii) For cost reporting periods beginning on or after October 1, 1993 through September 30, 1995, each hospital's per resident amount for the previous cost reporting period will not be adjusted for any resident FTEs who are not either a primary care resident or an obstetrics and gynecology resident.

(4) *Exceptions*—(i) *Base period for certain hospitals.* If a hospital did not have any approved medical residency training programs or did not participate in Medicare during the base period, but either condition changes in a cost reporting period beginning on or after July 1, 1985, the intermediary establishes a per resident amount for the hospital using the information from the first cost reporting period during which the hospital participates in Medicare and the residents are on duty during the first month of that period. Any graduate medical education program costs incurred by the hospital before that cost reporting period are reimbursed on a reasonable cost basis. The per resident amount is based on the lower of the following:

(A) The hospital's actual costs, incurred in connection with the graduate medical education program for the hospital's first cost reporting period in which residents were on duty during the first month of the cost reporting period.

(B) The mean value of per resident amounts of hospitals located in the same geographic wage area, as that term is used in the prospective payment system under part 412 of this chapter, for cost reporting periods beginning in the same fiscal years. If there are fewer than three amounts that can be used to calculate the mean value, the calculation of the per resident amounts includes all hospitals in the hospital's region as that term is used in § 412.62(f)(1)(i).

(ii) *Short or long base-period cost reporting periods.* If a hospital's base-period cost reporting period reflects graduate medical education costs for a period that is shorter than 50 weeks or longer than 54 weeks, the intermediary converts the allowable costs for the base period into a daily figure. The daily figure is then multiplied by 365 or

366, as appropriate, to derive the approved per resident amount for a 12-month base-period cost reporting period. If a hospital has two cost reporting periods beginning in the base period, the later period serves as the base-period cost reporting period.

(iii) *Short or long cost reporting periods beginning on or after July 1, 1985.* If a hospital's cost reporting period is shorter than 50 weeks or longer than 54 weeks, the hospital's intermediary should contact HCFA Central Office to receive a special CPI–U adjustment factor.

(f) *Determining the total number of FTE residents.* Subject to the weighting factors in paragraphs (g) and (h) of this section, the count of FTE residents is determined as follows:

(1) Residents in an approved program working in all areas of the hospital complex may be counted.

(2) No individual may be counted as more than one FTE. Except as provided in paragraphs (f)(3) and (4) of this section, if a resident spends time in more than one hospital or, in a nonprovider setting, the resident counts as partial FTE based on the proportion of time worked at the hospital to the total time worked. A part-time resident counts as a partial FTE based on the proportion of allowable time worked compared to the total time necessary to fill a full-time internship or residency slot.

(3) On or after July, 1, 1987 and for portions of cost reporting periods occurring before January 1, 1999, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs is not excluded in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met—

(i) The resident spends his or her time in patient care activities.

(ii) There is a written agreement between the hospital and the outside entity that states that the resident's compensation for training time spent outside of the hospital setting is to be paid by the hospital.

(4) For portions of cost reporting periods occurring on or after January 1, 1999, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met—

(i) The resident spends his or her time in patient care activities.

(ii) The written agreement between the hospital and the nonhospital site must indicate that the hospital will incur the cost of the resident's salary and fringe benefits while the resident is training in the nonhospital site and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities.

(iii) The hospital must incur all or substantially all of the costs for the training program in the nonhospital setting in accordance with the definition in paragraph (b) of this section.

(g) *Determining the weighted number of FTE residents.* Subject to the provisions in paragraph (h) of this section, HCFA determines a hospital's number of FTE residents by applying a weighting factor to each resident and then summing the resulting numbers that represent each resident. The weighting factor is determined as follows:

(1) For purposes of this section, an initial residency period is the number of years necessary to satisfy the minimum requirements for certification in a specialty or subspecialty, plus one year. Effective August 10, 1993, residents or fellows in an approved preventive medicine residency or fellowship program may also be counted as a full FTE resident for up to two additional years beyond the initial residency period limitations. Effective July 1, 1995, an initial residency period is defined as the minimum number of years required for board eligibility. An initial residency period may not exceed five years in order to be counted toward determining FTE status except in the case of fellows in an approved geriatric program whose initial residency period may last up to two additional years. For combined residency programs, an

initial residency period is defined as the time required for individual certification in the longer of the programs. If the resident is enrolled in a combined medical residency training program in which all of the individual programs (that are combined) are for training primary care residents (as defined in paragraph (b) of this section) or obstetrics and gynecology residents, the initial residency period is the time required for individual certification in the longer of the programs plus one year.

(i) For residency programs other than those specified in paragraphs (g)(1)(ii) and (g)(1)(iii) of this section, the initial residency period is the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training, as specified in the most recently published edition of the Graduate Medical Education Directory.

(ii) For residency programs in osteopathy, dentistry, and podiatry, the minimum requirement for certification in a specialty or subspecialty is the minimum number of years of formal training necessary to satisfy the requirements of the appropriate approving body listed in § 415.152 of this chapter.

(iii) For residency programs in geriatric medicine, accredited by the appropriate approving body listed in 415.152 of this chapter, these programs are considered approved programs on the later of—

(A) The starting date of the program within a hospital; or

(B) The hospital's cost reporting periods beginning on or after July 1, 1985.

(iv) The time spent in residency programs that do not lead to certification in a specialty or subspecialty, but that otherwise meet the definition of approved programs, as described in paragraph (b) of this section, is counted toward the initial residency period limitation.

(2) If the resident is in an initial residency period, the weighting factor is one.

(3) If the resident is not in an initial residency period, the weighting factor is 1.00 during the period beginning on or after July 1, 1985 and before July 1, 1986, .75 during the period beginning on or after July 1, 1986 and before July 1, 1987 and is .50 thereafter without regard to the hospital's cost reporting period.

(4) For purposes of determining direct graduate medical education payment, for cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted FTE count for residents in allopathic and osteopathic medicine may not exceed the hospital's unweighted FTE count for these residents for the most recent cost reporting period ending on or before December 31, 1996. If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 1997, exceeds the limit described in this paragraph (g), the hospital's weighted FTE count (before application of the limit) will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996. Hospitals that are part of the same affiliated group may elect to apply the limit on an aggregate basis. The fiscal intermediary may make appropriate modifications to apply the provisions of this paragraph (g)(4) based on the equivalent of a 12-month cost reporting period.

(5) For purposes of determining direct graduate medical education payment, for the hospital's first cost reporting period beginning on or after October 1, 1997, the hospital's weighted FTE count is equal to the average of the weighted FTE count for the payment year cost reporting period and the preceding cost reporting period. For cost reporting periods beginning on or after October 1, 1998, the hospital's weighted FTE count is equal to the average of the weighted FTE count for the payment year cost reporting period and the preceding two cost reporting periods. The fiscal intermediary may make appropriate modifications to apply the provisions of this paragraph based on the equivalent of 12-month cost reporting periods. If a hospital qualifies for an adjustment to the limit established under paragraph (g)(4) of this section for new medical residency programs created under paragraph

(g)(6) of this section, the count of residents participating in new medical residency training programs above the number included in the hospital's FTE count for the cost reporting period ending during calendar year 1996 is added after applying the averaging rules in this paragraph for a period of years. Residents participating in new medical residency training programs are included in the hospital's FTE count before applying the averaging rules after the period of years has expired. For purposes of this paragraph, the period of years equals the minimum accredited length for the type of program. The period of years begins when the first resident begins training.

(6) If a hospital establishes a new medical residency training program as defined in paragraph (g)(9) of this section on or after January 1, 1995, the hospital's FTE cap described under paragraph (g)(4) of this section may be adjusted as follows:

(i) If a hospital had no allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it establishes a new medical residency training program on or after January 1, 1995, the hospital's unweighted FTE resident cap under paragraph (g)(4) of this section may be adjusted based on the product of the highest number of residents in any program year during the third year of the first program's existence for all new residency training programs and the number of years in which residents are expected to complete the program based on the minimum accredited length for the type of program. The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program.

(A) If the residents are spending an entire program year (or years) at one hospital and the remainder of the program at another hospital, the adjustment to each respective hospital's cap is equal to the product of the highest number of residents in any program year during the third year of the first program's existence and the number of years the residents are training at each respective hospital.

(B) Prior to the implementation of the hospital's adjustment to its FTE cap beginning with the fourth year of the hospital's residency program(s), the hospital's cap may be adjusted during each of the first 3 years of the hospital's new residency program using the actual number of residents participating in the new program. The adjustment may not exceed the number of accredited slots available to the hospital for each program year.

(C) Except for rural hospitals, the cap will not be adjusted for new programs established more than 3 years after the first program begins training residents.

(D) An urban hospital that qualifies for an adjustment to its FTE cap under paragraph (g)(6)(i) of this section is not permitted to be part of an affiliated group for purposes of establishing an aggregate FTE cap.

(E) A rural hospital that qualifies for an adjustment to its FTE cap under paragraph (g)(6)(i) of this section is permitted to be part of an affiliated group for purposes of establishing an aggregate FTE cap.

(ii) If a hospital had allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, the hospital's unweighted FTE cap may be adjusted for new medical residency training programs established on or after January 1, 1995 and on or before August 5, 1997. The adjustment to the hospital's FTE resident limit for the new program is based on the product of the highest number of residents in any program year during the third year of the newly established program and the number of years in which residents are expected to complete each program based on the minimum accredited length for the type of program.

(A) If the residents are spending an entire program year (or years) at one hospital and the remainder of the program at another hospital, the adjustment to each respective hospital's cap is equal to the product of the highest number of residents in any program year during the third year of the first program's existence and the number of years the residents are training at each respective hospital.

(B) Prior to the implementation of the hospital's adjustment to its FTE cap beginning with the fourth year of the hospital's residency program, the

hospital's cap may be adjusted during each of the first 3 years of the hospital's new residency program, using the actual number of residents in the new programs. The adjustment may not exceed the number of accredited slots available to the hospital for each program year.

(iii) If a hospital with allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, is located in a rural area (or other hospitals located in rural areas that added residents under paragraph (g)(6)(i) of this section), the hospital's unweighted FTE limit may be adjusted in the same manner described in paragraph (g)(6)(ii) of this section to reflect the increase for residents in the new medical residency training programs established after August 5, 1997. For these hospitals, the limit will be adjusted for additional new programs but not for expansions of existing or previously existing programs.

(iv) A hospital seeking an adjustment to the limit on its unweighted resident count policy must provide documentation to its fiscal intermediary justifying the adjustment.

(7) A hospital that began construction of its facility prior to August 5, 1997, and sponsored new medical residency training programs on or after January 1, 1995 and on or before August 5, 1997, that either received initial accreditation by the appropriate accrediting body or temporarily trained residents at another hospital(s) until the facility was completed, may receive an adjustment to its FTE cap.

(i) The newly constructed hospital's FTE cap is equal to the lesser of:

(A) The product of the highest number of residents in any program year during the third year of the newly established program and the number of years in which residents are expected to complete the programs based on the minimum accredited length for each type of program; or

(B) The number of accredited slots available to the hospital for each year of the programs.

(ii) If the new medical residency training programs sponsored by the newly constructed hospital have been in existence for 3 years or more by the time the residents begin training at the newly constructed hospital, the newly constructed hospital's cap will be based on the number of residents training in the third year of the programs begun at the temporary training site.

(iii) If the new medical residency training programs sponsored by the newly constructed hospital have been in existence for less than 3 years by the time the residents begin training at the newly constructed hospital, the newly constructed hospital's cap will be based on the number of residents training at the newly constructed hospital in the third year of the programs (including the years at the temporary training site).

(iv) A hospital that qualifies for an adjustment to its FTE cap under paragraph (g)(7) of this section may be part of an affiliated group for purposes of establishing an aggregate FTE cap.

(v) The provisions of this paragraph (g)(7) are applicable during portions of cost reporting periods occurring on or after October 1, 1999.

(8) A hospital may receive a temporary adjustment to its FTE cap to reflect residents added because of another hospital's closure if the hospital meets the following criteria:

(i) The hospital is training additional residents from a hospital that closed on or after July 1, 1996.

(ii) No later than 60 days after the hospital begins to train the residents, the hospital submits a request to its fiscal intermediary for a temporary adjustment to its FTE cap, documents that the hospital is eligible for this temporary adjustment by identifying the residents who have come from the closed hospital and have caused the hospital to exceed its cap, and specifies the length of time the adjustment is needed.

(iii) For purposes of paragraph (g)(8) of this section, ''closure'' means the hospital terminates its Medicare agreement under the provisions of §489.52 of this chapter.

(9) For purposes of paragraph (g) of this section, a new medical residency training program means a medical residency that receives initial accreditation by the appropriate accrediting

body or begins training residents on or after January 1, 1995.

(h) *Determination of weighting factors for foreign medical graduates.* (1) The weighting factor for a foreign medical graduate is determined under the provisions of paragraph (g) of this section if the foreign medical graduate—

(i) Has passed FMGEMS; or

(ii) Before July 1, 1986, received certification from, or passed an examination of, the Educational Committee for Foreign Medical Graduates.

(2) Before July 1, 1986, the weighting factor for a foreign medical graduate is 1.0 times the weight determined under the provisions of paragraph (g) of this section. On or after July 1, 1986, and before July 1, 1987, the weighting factor for a graduate of a foreign medical school who was in a residency program both before and after July 1, 1986 but who does not meet the requirements set forth in paragraph (h)(1) of this section is .50 times the weight determined under the provisions of paragraph (g) of this section.

(3) On or after July 1, 1987, these foreign medical graduates are not counted in determining the number of FTE residents.

(4) During the cost reporting period in which a foreign medical graduate passes FMGEMS, the weighting factor for that resident is determined under the provisions of paragraph (g) of this section for the part of the cost reporting period beginning with the month the resident passes the test.

(5) On or after September 1, 1989, the National Board of Medical Examiners Examination, Parts I and II, may be substituted for FMGEMS for purposes of the determination made under paragraphs (h)(1) and (h)(4) of this section.

(6) On or after June 1, 1992, the United States Medical Licensing Examination may be substituted for the FMGEMS for purposes of the determination made under paragraphs (h)(1) and (h)(4) of this section. On or after July 1, 1993 only the results of steps I and II of the United States Medical Licensing Examination shall be accepted for purposes of making this determination.

(i) To include a resident in the FTE count for a particular cost reporting period, the hospital must furnish the following information.

The information must be certified by an official of the hospital and, if different, an official responsible for administering the residency program.

(1) The name and social security number of the resident.

(2) The type of residency program in which the individual participates and the number of years the resident has completed in all types of residency programs.

(3) The dates the resident is assigned to the hospital and any hospital-based providers.

(4) The dates the resident is assigned to other hospitals, or other freestanding providers, and any nonprovider setting during the cost reporting period, if any.

(5) The name of the medical, osteopathic, dental, or podiatric school from which the resident graduated and the date of graduation.

(6) If the resident is an FMG, documentation concerning whether the resident has satisfied the requirements of paragraph (h) of this section.

(7) The name of the employer paying the resident's salary.

(j) *Special rules for States that formerly had a waiver from Medicare reimbursement principles.* (1) Effective for cost reporting periods beginning on or after January 1, 1986, hospitals in States that, prior to becoming subject to the prospective payment system, had a waiver for the operation of a State reimbursement control system under section 1886(c) of the Act, section 402 of the Social Security Amendments of 1967 (42 U.S.C. 1395b–1 or section 222(a) of the Social Security Amendment of 1972 (42 U.S.C. 1395b–1 (note)) are permitted to change the order in which they allocate administrative and general costs to the order specified in the instructions for the Medicare cost report.

(2) For hospitals making this election, the base-period costs for the purpose of determining the per resident amount are adjusted to take into account the change in the order by which they allocate administrative and general costs to interns and residents in approved program cost centers.

(3) Per resident amounts are determined for the base period and updated as described in paragraph (e) of this section. For cost reporting periods beginning on or after January 1, 1986, payment is made based on the methodology described in paragraph (d) of this section.

(k) *Adjustment of a hospital's target amount or prospective payment hospital-specific rate*—(1) *Misclassified operating costs*—(i) *General rule.* If a hospital has its base-period graduate medical education costs reduced under paragraph (e)(1) of this section because those costs included misclassified operating costs, the hospital may request that the intermediary review the classification of the affected costs in its rate-of-increase ceiling or prospective payment base year for purposes of adjusting the hospital's target amount or hospital-specific rate. For those cost reports that are not subject to reopening under §405.1885 of this chapter, the hospital's reopening request must explicitly state that the review is limited to this one issue.

(ii) *Request for review.* The hospital must request review of the classification of its rate of increase ceiling or prospective payment base year costs no later than 180 days after the date of the notice by the intermediary of the hospital's base-period average per resident amount. A hospital's request for review must include sufficient documentation to demonstrate to the intermediary that adjustment of the hospital's hospital-specific rate or target amount is warranted.

(iii) *Effect of intermediary's review.* If the intermediary, upon review of the hospital's costs, determines that the hospital's hospital-specific rate or target amount should be adjusted, the adjustment of the hospital-specific rate or the target amount is effective for the hospital's cost reporting periods subject to the prospective payment system or the rate-of-increase ceiling that are still subject to reopening under §405.1885 of this chapter.

(2) *Misclassification of graduate medical education costs*—(i) *General rule.* If costs that should have been classified as graduate medical education costs were treated as operating costs during both the graduate medical education base period and the rate-of-increase ceiling base year or prospective payment base year and the hospital wishes to receive benefit for the appropriate classification of these costs as graduate medical education costs in the graduate medical education base period, the hospital must request that the intermediary review the classification of the affected costs in the rate-of-increase ceiling or prospective payment base year for purposes of adjusting the hospital's target amount or hospital-specific rate. For those cost reports that are not subject to reopening under §405.1885 of this chapter, the hospital's reopening request must explicitly state that the review is limited to this one issue.

(ii) *Request for review.* The hospital must request review of the classification of its costs no later than 180 days after the date of the intermediary's notice of the hospital's base-period average per resident amount. A hospital's request for review must include sufficient documentation to demonstrate to the intermediary that modification of the adjustment of the hospital's hospital-specific rate or target amount is warranted.

(iii) *Effect of intermediary's review.* If the intermediary, upon review of the hospital's costs, determines that the hospital's hospital-specific rate or target amount should be adjusted, the adjustment of the hospital-specific rate and the adjustment of the target amount is effective for the hospital's cost reporting periods subject to the prospective payment system or the rate-of-increase ceiling that are still subject to reopening under §405.1885 of this chapter.

[54 FR 40316, Sept. 29, 1989; 55 FR 290, Jan. 4, 1990, as amended at 56 FR 43243, Aug. 30, 1991; 57 FR 39830, Sept. 1, 1992; 58 FR 46343, Sept. 1, 1993; 59 FR 45401, Sept. 1, 1994; 60 FR 63189, Dec. 8, 1995; 61 FR 46225, Aug. 30, 1996; 62 FR 46034, Aug. 29, 1997; 63 FR 26358, May 12, 1998; 63 FR 41005, July 31, 1998; 64 FR 41542, July 30, 1999]

§ 413.88 Incentive payments under plans for voluntary reduction in number of medical residents.

(a) *Statutory basis.* This section implements section 1886(h)(6) of the Act, which establishes a program under which incentive payments may be

made to qualifying entities that develop and implement approved plans to voluntarily reduce the number of residents in medical residency training.

(b) *Qualifying entity defined.* ''Qualifying entity'' means:

(1) An individual hospital that is operating one or more approved medical residency training programs as defined in §413.86(b) of this chapter; or

(2) Two or more hospitals that are operating approved medical residency training programs as defined in §413.86(b) of this chapter and that submit a residency reduction application as a single entity.

(c) *Conditions for payments.* (1) A qualifying entity must submit an application for a voluntary residency reduction plan that meets the requirements and conditions of this section in order to receive incentive payments for reducing the number of residents in its medical residency training programs.

(2) The incentive payments will be determined as specified under paragraph (g) of this section.

(d) *Requirements for voluntary plans.* In order for a qualifying entity to receive incentive payments under a voluntary residency reduction plan, the qualifying entity must submit an application that contains the following information, documents, and agreements—

(1) A description of the operation of a plan for reducing the full-time equivalent (FTE) residents in its approved medical residency training programs, consistent with the percentage reduction requirements specified in paragraphs (g)(2) and (g)(3) of this section;

(2) An election of the period of residency training years during which the reductions will occur. The reductions must be fully implemented by not later than the fifth residency training year in which the plan is effective;

(3) FTE counts for the base number of residents, as defined in paragraph (g)(1) of this section, with a breakdown of the number of primary care residents compared to the total number of residents; and the direct and indirect FTE counts of the entity on June 30, 1997. For joint applicants, these counts must be provided individually and collectively;

(4) Data on the annual and cumulative targets for reducing the number of FTE residents and the ratios of the number of primary care residents to the total number of residents for the base year and for each year in the 5-year reduction period. For joint applicants, these data must be provided individually and collectively;

(5) An agreement to not reduce the proportion of its primary care residents to its total number of residents below the proportion that exists in the base year, as specified in paragraph (g)(1) of this section;

(6) An agreement to comply with data submission requirements deemed necessary by HCFA to make annual incentive payments during the 5-year residency reduction plan, and to fully cooperate with additional audit and monitoring activities deemed necessary by HCFA;

(7) For a qualifying entity that is a member of an affiliated group as defined in §413.86(b), a statement that all members of the group agree to an aggregate FTE cap that reflects—

(i) The reduction in the qualifying entity's FTE count as specified in the plan during each year of the plan; and

(ii) The 1996 FTE count of the other hospital(s) in the affiliated group.

(8) A statement indicating voluntary participation in the plan under the terms of this section, signed by each hospital that is part of the applying entity.

(e) *Deadline for applications.* A qualifying entity must submit an application that meets the requirements of paragraph (d) of this section at least one day prior to the first day of the period to which the plan would be effective but no later than November 1, 1999. The application must be submitted to the fiscal intermediary, with a copy to HCFA.

(f) *Effective dates of plans.* Residency reduction plans that are submitted to the fiscal intermediary on or after September 17, 1999 but on or before November 1, 1999, may be effective for portions of cost reporting periods beginning no earlier than the day after the date of the application.

(g) *Residency reduction requirements*—(1) *Base number of residents defined.* (i)

''Base number of residents'' means the lesser of—

(A) The number of FTE residents in all approved medical residency training programs of the qualifying entity (before application of weighting factors under §413.86(g)) for the most recent residency training year ending June 30, 1996; or

(B) The number of FTE residents in all approved medical residency training programs of the qualifying entity (before application of weighting factors under §413.86(g)) for any subsequent residency training year that ends before the date the entity submits its plan to the fiscal intermediary and HCFA.

(ii) The residency training year used to determine the base number of residents is the ''base year'' for determining reduction requirements.

(iii) The qualifying entity's base number of residents may not be adjusted to reflect adjustments that may otherwise be made to the entity's FTE caps for new medical residency training programs.

(2) *Qualifying entity consisting of individual hospital.* The base number of FTE residents in all the approved medical residency training programs operated by or through a qualifying entity consisting of an individual hospital must be reduced as follows:

(i) If the base number of residents exceeds 750, residents, by at least 20 percent of the base number.

(ii) If the base number of residents exceeds 600 but is less than or equal to 750 residents—

(A) By 150 residents; or

(B) By 20 percent, if the qualifying entity increases the number of primary care residents included in the base number by at least 20 percent.

(iii) If the base number of residents is 600 or less residents—

(A) By 25 percent; or

(B) By 20 percent, if the qualifying entity increases the number of primary care residents included in the base number of residents by at least 20 percent.

(3) *Qualifying entity consisting of two or more hospitals.* The base number of FTE residents in the aggregate for all the approved medical residency training programs operated by or through a qualifying entity consisting of two or more hospitals must be reduced—

(i) By 25 percent; or

(ii) By 20 percent, if the qualifying entity increases the number of primary care residents included in the base number of residents by at least 20 percent.

(4) *Treatment of rotating residents.* A qualifying entity will not be eligible for incentive payments for a reduction in the base number of residents if the reduction is a result of the entity rotating residents to another hospital that is not a part of its voluntary residency reduction plan.

(5) *Updates to annual and cumulative targets* (i) Except as provided in paragraph (g)(5)(ii) of this section an entity with an approved voluntary residency reduction plan may not change the annual and cumulative reduction targets that are specified in its plan in accordance with paragraphs (g)(2) and (g)(3) of this section.

(ii) An entity may update annual reduction targets specified in its plan only if—

(A) It has failed to meet a specified annual target for a plan year in the 5-year period; and

(B) It wishes to adjust future annual targets for the remaining years of the plan in order to comply with its cumulative target.

(iii) An updated plan allowed under paragraph (g)(5)(ii) of this section must be submitted prior to the beginning of each July 1 medical residency training year during the plan years.

(h) *Computation of incentive payment amount.* (1) Incentive payments to qualifying entities that meets the requirements and conditions of paragraphs (d) and (g) of this section will be computed as follows:

(i) *Step 1.* Determine the amount (if any) by which the payment amount that would have been made under §413.86(d) if there had been a 5-percent reduction in the number of FTE residents in the approved medical education training programs of the hospital as of June 30, 1997, exceeds the amount of payment that would have been made under §413.86(d) in each year

under the voluntary residency reduction plan, taking into account the reduction in the number of FTE residents under the plan.

(ii) *Step 2.* Determine the amount (if any) by which the payment amount that would have been made under §412.105 of this chapter if there had been a 5-percent reduction in the number of FTE residents in the approved medical education training programs of the hospital as of June 30, 1997, exceeds the payment amount made under §412.105 of this chapter in each year under the voluntary residency reduction plan, taking into account the actual reduction in the number of FTE residents.

(iii) *Step 3.* Determine the amount (if any) by which the payment amount that would have been made under §412.322 of this chapter if there had been a 5-percent reduction in the number of FTE residents in the approved medical education training programs of the hospital as of June 30, 1997, exceeds the payment amount made under §412.322 of this chapter in each year under the voluntary residency reduction plan, taking into account the actual reduction in the number of FTE residents.

(iv) *Step 4.* Multiply the sum of the amounts determined under paragraph (h)(i), (ii), and (iii) of this section by the applicable hold harmless percentages specified in paragraph (i) of this section.

(2) The determination of the amounts under paragraph (h)(1) of this section for any year is based on the applicable Medicare statutory provisions in effect on the application deadline date for the voluntary reduction plan specified under paragraph (e) of this section.

(i) *Applicable hold-harmless percentage.* The applicable hold-harmless percentages for each year in which the residency reduction plan is in effect are as follows:

(1) 100 percent for the first and second residency training years;

(2) 75 percent for the third year;

(3) 50 percent for the fourth year; and

(4) 25 percent for the fifth year.

(j) *Payments to qualifying entities.* Annual incentive payments through cost reports will be made to each hospital that is or is part of a qualifying entity over the 5-year reduction period if the qualifying entity meets the annual and cumulative reduction targets specified in its voluntary reduction plan.

(k) *Penalty for noncompliance*—(1) *Nonpayment.* No incentive payment may be made to a qualifying entity for a residency training year if the qualifying entity has failed to reduce the number of FTE residents according to its voluntary residency reduction plan.

(2) *Repayment of incentive amounts.* The qualifying entity is liable for repayment of the total amount of incentive payments it has received if the qualifying entity—

(i) Fails to reduce the base number of residents by the percentages specified in paragraphs (g)(2) and (g)(3) of this section by the end of the fifth residency training year; or

(ii) Increases the number of FTE residents above the number of residents permitted under the voluntary residency reduction plan as of the completion date of the plan.

(l) *Postplan determination of FTE caps for qualifying entities*—(1) *No penalty imposed.* Upon completion of a voluntary residency reduction plan, if no penalty is imposed, the qualifying entity's 1996 FTE count is permanently adjusted to equal the unweighted FTE count used for direct GME payments for the last residency training year in which a qualifying entity participates.

(2) *Penalty imposed.* Upon completion of the voluntary residency reduction plan—

(i) *During repayment period.* If a penalty is imposed under paragraph (k)(2) of this section, during the period of repayment, the qualifying entity's FTE count is as specified in paragraph (l)(1) of this section.

(ii) *After repayment period.* Once the penalty repayment is completed, the qualifying entity's FTE reverts back to its original 1996 FTE cap.

[64 FR 44855, Aug. 18, 1999]

§413.90 Research costs.

(a) *Principle.* Costs incurred for research purposes, over and above usual patient care, are not includable as allowable costs.

(b) *Application.* (1) There are numerous sources of financing for health-related research activities. Funds for this

purpose are provided under many Federal programs and by other tax-supported agencies. Also, many foundations, voluntary health agencies, and other private organizations, as well as individuals, sponsor or contribute to the support of medical and related research. Funds available from such sources are generally ample to meet basic medical and hospital research needs. A further consideration is that quality review should be assured as a condition of governmental support for research. Provisions for such review would introduce special difficulties in the Medicare programs.

(2) If research is conducted in conjunction with, and as a part of, the care of patients, the costs of usual patient care and studies, analyses, surveys, and related activities to serve the provider's administrative and program needs are allowable costs in the determination of payment under Medicare.

[51 FR 34793, Sept. 30, 1986, as amended at 61 FR 63748, Dec. 2, 1996]

§ 413.92 Costs of surety bonds.

Costs incurred by a provider to obtain a surety bond required by part 489, subpart F of this chapter are not included as allowable costs.

[63 FR 310, Jan. 5, 1998]

§ 413.94 Value of services of nonpaid workers.

(a) *Principle.* The value of services in positions customarily held by full-time employees performed on a regular, scheduled basis by individuals as nonpaid members of organizations under arrangements between such organizations and a provider for the performance of such services without direct remuneration from the provider to such individuals is allowable as an operating expense for the determination of allowable cost subject to the limitation contained in paragraph (b) of this section. The amounts allowed are not to exceed those paid others for similar work. Such amounts must be identifiable in the records of the institutions as a legal obligation for operating expenses.

(b) *Limitations: Services of nonpaid workers.* The services must be performed on a regular, scheduled basis in positions customarily held by full-time employees and necessary to enable the provider to carry out the functions of normal patient care and operation of the institution. The value of services of a type for which providers generally do not remunerate individuals performing such services is not allowable as a reimbursable cost under the Medicare program. For example, donated services of individuals in distributing books and magazines to patients, or in serving in a provider canteen or cafeteria or in a provider gift shop, would not be reimbursable.

(c) *Application.* The following illustrates how a provider would determine an amount to be allowed under this principle: The prevailing salary for a lay nurse working in Hospital A is $5,000 for the year. The lay nurse receives no maintenance or special perquisites. A sister working as a nurse engaged in the same activities in the same hospital receives maintenance and special perquisites which cost the hospital $2,000 and are included in the hospital's allowable operating costs. The hospital would then include in its records an additional $3,000 to bring the value of the services rendered to $5,000. The amount of $3,000 would be allowable if the provider assumes obligation for the expense under a written agreement with the sisterhood or other religious order covering payment by the provider for the services.

§ 413.98 Purchase discounts and allowances, and refunds of expenses.

(a) *Principle.* Discounts and allowances received on purchases of goods or services are reductions of the costs to which they relate. Similarly, refunds of previous expense payments are reductions of the related expense.

(b) *Definitions*—(1) *Discounts.* Discounts, in general, are reductions granted for the settlement of debts.

(2) *Allowances.* Allowances are deductions granted for damage, delay, shortage, imperfection, or other causes, excluding discounts and returns.

(3) *Refunds.* Refunds are amounts paid back or a credit allowed on account of an overcollection.

(c) *Normal accounting treatment—Reduction of costs.* All discounts, allowances, and refunds of expenses are reductions in the cost of goods or services purchased and are not income. If they are received in the same accounting period in which the purchases were made or expenses were incurred, they will reduce the purchases or expenses of that period. However, if they are received in a later accounting period, they will reduce the comparable purchases or expenses in the period in which they are received.

(d) *Application.* (1) Purchase discounts have been classified as cash, trade, or quantity discounts. Cash discounts are reductions granted for the settlement of debts before they are due. Trade discounts are reductions from list prices granted to a class of customers before consideration of credit terms. Quantity discounts are reductions from list prices granted because of the size of individual or aggregate purchase transactions. Whatever the classification of purchase discounts, like treatment in reducing allowable costs is required. In the past, purchase discounts were considered as financial management income. However, modern accounting theory holds that income is not derived from a purchase but rather from a sale or an exchange and that purchase discounts are reductions in the cost of whatever was purchased. The true cost of the goods or services is the net amount actually paid for them. Treating purchase discounts as income would result in an overstatement of costs to the extent of the discount.

(2) As with discounts, allowances, and rebates received from purchases of goods or services, refunds of previous expense payments are clearly reductions in costs and must be reflected in the determination of allowable costs. This treatment is equitable and is in accord with that generally followed by other governmental programs and third-party payment organizations paying on the basis of cost.

§ 413.100 Special treatment of certain accrued costs.

(a) *Principle.* As described in § 413.24(b)(2), under the accrual basis of accounting, revenue is reported in the period in which it is earned and expenses are reported in the period in which they are incurred. In the case of accrued costs described in this section, for Medicare payment purposes the costs are allowable in the year in which the costs are accrued and claimed for Medicare payment only under the conditions set forth in paragraph (c) of this section.

(b) *Definitions*—(1) *All-inclusive paid days off benefit.* An all-inclusive paid days off benefit replaces other vacation and sick pay plans. It is a formal plan under which, based on actual hours worked, all employees accrue vested leave or payment in lieu of vested leave for any combination of types of leave, such as illness, medical appointments, holidays, and vacations.

(2) *Self-insurance.* Self-insurance is a means by which a provider independently or as part of a group undertakes the risk of protecting itself against anticipated liabilities by providing funds in an amount equal to anticipated liabilities, rather than by purchasing insurance coverage.

(c) *Recognition of accrued costs*—(1) *General.* Although Medicare recognizes, in the year of accrual, the accrual of costs for which a provider has not actually expended funds during the current cost reporting period, for purposes of payment Medicare does not recognize the accrual of costs unless the related liabilities are liquidated timely.

(2) *Requirements for liquidation of liabilities.* For accrued costs to be recognized for Medicare payment in the year of the accrual, the requirements set forth below must be met with respect to the liquidation of related liabilities. If liquidation does not meet these requirements, the cost is disallowed, generally in the year of accrual, except as specified in paragraph (c)(2)(ii) of this section.

(i) *A short-term liability.* (A) Except as provided in paragraph (c)(2)(i)(B) of this section, a short-term liability, including the current portion of a long-term liability (for example, mortgage interest payments due to be paid in the current year), must be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred.

(B) If, within the 1-year time limit, the provider furnishes to the intermediary sufficient written justification (based upon documented evidence) for nonpayment of the liability , the intermediary may grant an extension for good cause. The extension may not exceed 3 years beyond the end of the cost reporting year in which the liability was incurred.

(ii) *Vacation pay and all-inclusive paid days off.* (A) If the provider's vacation policy, or its policy for all-inclusive paid days off, is consistent for all employees, liquidation of the liability must be made within the period provided for by that policy.

(B) If the provider's vacation policy, or its policy for all-inclusive paid days off, is not consistent for all employees, liquidation of the liability must be made within 2 years after the close of the cost reporting period in which the liability is accrued.

(C) If payment is not made within the required time period or if benefits are forfeited by the employee, an adjustment to disallow the accrued cost is made in the current period (that is, the latest year in which payment should have been made or the year in which the benefits are forfeited) rather than in the period in which the cost was accrued and claimed for Medicare payment. However, an intermediary may choose to require the adjustment in the period in which the cost was accrued and claimed for Medicare payment if the cost report for that period is open or can be reopened as provided in § 405.1885 of this chapter, and if the intermediary believes the adjustment is more appropriate in that period.

(iii) *Sick pay.* (A) If sick leave is vested and funded in a deferred compensation plan, liabilities related to the contributions to the fund must be liquidated, generally within 1 year after the end of the cost reporting period in which the liability is incurred. If, within the 1-year time limit, the provider furnishes to the intermediary sufficient written justification (based upon documented evidence) for nonpayment of the liability, the intermediary may grant an extension for good cause. The extension may not exceed 3 years beyond the end of the cost reporting year in which the liability was incurred. Contributions to the deferred compensation plan must be reduced to reflect estimated forfeitures. Actual forfeitures above or below estimated forfeitures must be used to adjust annual contributions to the fund.

(B) If the sick leave plan grants employees the nonforfeitable right to demand cash payment for unused sick leave at the end of each year, sick pay is includable in allowable costs, without funding, in the cost reporting period in which it is earned.

(C) Sick pay paid on any basis other than that specified in paragraphs (c)(2)(iii) (A) or (B) of this section can be claimed for Medicare payment only on a cash basis for the year in which the benefits are paid.

(iv) *Compensation of owners.* Accrued liability related to compensation of owners other than sole proprietors and partners must be liquidated within 75 days after the close of the cost reporting period in which the liability occurs.

(v) *Nonpaid workers.* Obligations incurred under a legally-enforceable agreement to remunerate an organization of nonpaid workers must be discharged no later than the end of the provider's cost reporting period following the period in which the services were furnished.

(vi) *FICA and other payroll taxes—(A) General rule.* The provider's share of FICA and other payroll taxes that the provider becomes obligated to remit to governmental agencies is included in allowable costs only during the cost reporting period in which payment (upon which the payroll taxes are based) is actually made to the employee. For example, payroll taxes applicable to vacation benefits are not to be accrued in the period in which the vacation benefits themselves are accrued but rather are allowable only in the period in which the employee takes the vacation.

(B) *Exception.* If payment would be made to an employee during a cost reporting period but for the fact the regularly scheduled payment date is after the end of the period, costs of accrued payroll taxes related to the portion of payroll accrued through the end of the period, but paid to the employee after the beginning of the new period, are allowable costs in the year of accrual,

subject to the liquidation requirements specified in paragraph (c)(2)(i) of this section.

(vii) *Deferred compensation.* (A) Reasonable provider payments made under unfunded deferred compensation plans are included in allowable costs only during the cost reporting period in which actual payment is made to the participating employee.

(B) Accrued liability related to contributions to a funded deferred compensation plan must be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred. An extension, not to exceed 3 years beyond the end of the cost reporting year in which the liability was incurred, may be granted by the intermediary for good cause if the provider, within the 1-year time limit, furnishes to the intermediary sufficient written justification for non-payment of the liability.

(C) Postretirement benefit plans (including those addressed in Statement of Financial Accounting Standards No. 106 (December 1990)) are deferred compensation arrangements and thus are subject to the provisions of this section regarding deferred compensation and to applicable program instructions for determining Medicare payment for deferred compensation.

(viii) *Self-insurance.* Accrued liability related to contributions to a self-insurance program that are systematically made to a funding agency and that cover malpractice and comprehensive general liability, unemployment compensation, workers' compensation insurance losses, or employee health benefits, must be liquidated within 75 days after the close of the cost reporting period.

[60 FR 33136, June 27, 1995, as amended at 64 FR 51909, Sept. 27, 1999]

EFFECTIVE DATE NOTE: At 64 FR 51909, Sept. 27, 1999, § 413.100 was amended by revising paragraph (c)(2)(vi), effective Nov. 26, 1999. For the convenience of the user, the superseded text is set forth as follows:

§ 413.100 Special treatment of certain accrued costs.

* * * * *

(c) * * *

(2) * * *

(vi) *FICA and other payroll taxes.* The provider's share of FICA and other payroll taxes that the provider becomes obligated to remit to governmental agencies is included in allowable costs only during the cost reporting period in which payment (upon which the tax is based) is actually made to the employee. For example, no legal obligation exists for a provider-employer to pay FICA taxes until the employee is paid and the specific amount of liability known.

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§ 413.102 Compensation of owners.

(a) *Principle.* A reasonable allowance of compensation for services of owners is an allowable cost provided that the services are actually performed in a necessary function.

(b) *Definitions.* (1) *Compensation.* Compensation means the total benefit received by the owner for the services he furnishes to the institution. It includes the following items:

(i) Salary amounts paid for managerial, administrative, professional, and other services.

(ii) Amounts paid by the institution for the personal benefit of the proprietor.

(iii) The cost of assets and services that the proprietor receives from the institution.

(iv) Deferred compensation.

(2) *Reasonableness.* Reasonableness requires that the compensation allowance—

(i) Be such an amount as would ordinarily be paid for comparable services by comparable institutions; and

(ii) Depend upon the facts and circumstances of each case.

(3) *Necessary.* Necessary requires that the function be—

(i) Such that had the owner not furnished the services, the institution would have had to employ another person to perform the services; and

(ii) Pertinent to the operation and sound conduct of the institution.

(c) *Application.* (1) Owners of provider organizations often furnish services as managers, administrators, or in other capacities. In such cases, it is equitable that reasonable compensation for the services furnished to be an allowable cost. To do otherwise would disadvantage such owners in comparison with

corporate providers or providers employing persons to perform similar services.

(2) Ordinarily, compensation paid to proprietors is a distribution of profits. However, if a proprietor furnishes necessary services for the institution, the institution is in effect employing his services, and a reasonable compensation for these services is an allowable cost. In corporate providers, the salaries of owners who are also employees are subject to the same requirements of reasonableness. If the services are furnished on less than a full-time basis, the allowable compensation should reflect an amount proportionate to a full-time basis. Reasonableness of compensation may be determined by reference to, or in comparison with, compensation paid for comparable services and responsibilities in comparable institutions; or it may be determined by other appropriate means.

§ 413.106 Reasonable cost of physical and other therapy services furnished under arrangements.

(a) *Principle.* The reasonable cost of the services of physical, occupational, speech, and other therapists, and services of other health specialists (other than physicians), furnished under arrangements (as defined in section 1861(w) of the Act) with a provider of services, a clinic, a rehabilitation agency or a public health agency, may not exceed an amount equivalent to the prevailing salary and additional costs that would reasonably have been incurred by the provider or other organization had such services been performed by such person in an employment relationship, plus the cost of other reasonable expenses incurred by such person in furnishing services under such an arrangement. However, if the services of a therapist are required on a limited part-time basis, or to perform intermittent services, payment may be made on the basis of a reasonable rate per unit of service, even though this rate may be greater per unit of time than salary-related amounts, if the greater payment is, in the aggregate, less than the amount that would have been paid had a therapist been employed on a full-time or regular part-time salaried basis. Pursuant to section 17(a) of Public Law 93–233 (87 Stat. 967), the provisions of this section are effective for cost reporting periods beginning after March, 1975.

(b) *Definitions*—(1) *Prevailing salary.* The prevailing salary is the hourly salary rate based on the 75th percentile of salary ranges paid by providers in the geographical area, by type of therapy, to therapists working full time in an employment relationship.

(2) *Fringe benefit and expense factor.* The standard fringe benefit and expense factor is an amount that takes account of fringe benefits, such as vacation pay, insurance premiums, pension payments, allowances for job-related training, meals, etc., generally received by an employee therapist, as well as expenses, such as maintaining an office, appropriate insurance, etc., an individual not working as an employee might incur in furnishing services under arrangements.

(3) *Adjusted hourly salary equivalency amount.* The adjusted hourly salary equivalency amount is the prevailing hourly salary rate plus the standard fringe benefit and expense factor. This amount is determined on a periodic basis for appropriate geographical areas.

(4) *Travel allowance.* A standard travel allowance is an amount that is recognized, in addition to the adjusted hourly salary equivalency amount.

(5) *Limited part-time or intermittent services.* Therapy services are considered to be on a limited part-time or intermittent basis if the provider or other organization furnishing the services under arrangements requires the services of a therapist or therapists on an average of less than 15 hours per week. This determination is made by dividing the total hours of services furnished during the cost reporting period by the number of weeks in which the services were furnished in the cost reporting period regardless of the number of days in each week in which services were performed.

(6) *Guidelines.* Guidelines are the amounts published by HCFA reflecting the application of paragraphs (b) (1) through (4) of this section to an individual therapy service and a geographical area. Other statistically valid data may be used to establish

guidelines for a geographical area, provided that the study designs, questionnaires and instructions, as well as the resultant survey data for determining the guidelines are submitted to and approved in advance by HCFA. Such data must be arrayed so as to permit the determination of the 75th percentile of the range of salaries paid to full-time employee therapists.

(7) *Administrative responsibility.* Administrative responsibility is the performance of those duties that normally fall within the purview of a department head or other supervisor. This term does not apply to directing aides or other assistants in furnishing direct patient care.

(c) *Application.* (1) Under this provision, HCFA will establish criteria for use in determining the reasonable cost of physical, occupational, speech, and other therapy services and the services of other health specialists (other than physicians) furnished by individuals under arrangements with a provider of services, a clinic, a rehabilitation agency, or public health agency. It is recognized that providers have a wide variety of arrangements with such individuals. These individuals may be independent practitioners or employees of organizations furnishing various health care specialists. This provision does not require change in the substance of these arrangements.

(2) If therapy services are performed under arrangements at a provider site on a full-time or regular part-time basis, the reasonable cost of such services may not exceed the amount determined by taking into account the total number of hours of services furnished by the therapist, the adjusted hourly salary equivalency amount appropriate for the particular therapy in the geographical area in which the services are furnished and a standard travel allowance.

(3) If therapy services are performed under arrangements on a limited part-time or intermittent basis at the provider site, the reasonable cost of such services is evaluated on a reasonable rate per unit of service basis, except that payment for these services, in the aggregate, during the cost reporting period, may not exceed the amount that would be determined to be reasonable under paragraph (c)(2) of this section, had a therapist furnished the provider or other organization furnishing the services under arrangements 15 hours of service per week on a regular part-time basis for the weeks in which services were furnished by the non-employee therapist.

(4) If an HHA furnishes services under arrangements at the patient's residence or in other situations in which therapy services are not performed at the provider's site, the reasonable cost of such services is evaluated as follows:

(i) *Time records available.* If time records of HHA visits are maintained by the provider, the reasonable cost of such services is evaluated on a unit-of-time basis, by taking into account the total number of hours of service furnished by the therapist, the adjusted hourly salary equivalency amount appropriate for the particular therapy in the geographical area in which the services are furnished, and a standard travel allowance for each visit. However, if the travel time of the therapist is accurately recorded by the therapist, and approved and maintained by the provider, the reasonable cost of such services may be evaluated, at the option of the provider, by taking into account the total number of hours of service furnished by the therapist, including travel time, and the adjusted hourly salary equivalency amount appropriate for the particular therapy in the geographical area in which the services are furnished. This option does not apply to services furnished by HHAs under arrangements with providers other than HHAs.

(ii) *No time records available.* If time records are unavailable or found to be inaccurate, each HHA visit is considered the equivalent of one hour of service. In such cases, the reasonable cost of such services is determined by taking into account the number of visits made by the therapist under arrangements with such agency, the adjusted hourly salary equivalency amount appropriate for the particular therapy in the geographical area in which the services are furnished, and a standard travel allowance.

(iii) *Limited part-time or intermittent services.* If under paragraph (c)(4) (i) or

(ii) of this section, the provider required therapy services on an average of less than 15 hours per week, the services are considered limited part-time or intermittent services, and the reasonable cost of such services is evaluated on a reasonable rate per unit of service basis as described in paragraph (c)(3) of this section.

(5) If therapy services are performed in situations where compensation to a therapist employed by the provider is based, at least in part, on a fee-for-service or on a percentage of income (or commission), the guidelines will apply. The entire compensation will be subject to the guidelines in cases where the nature of the arrangements is most like an under ''arrangement'' situation, although technically the provider may treat the therapists as employees. The intent of this section is to prevent an employment relationship from being used to circumvent the guidelines.

(6) These provisions are applicable to individual therapy services or disciplines by means of separate guidelines by geographical area and apply to costs incurred after issuance of the guidelines but no earlier than the beginning of the provider's cost reporting period described in paragraph (a) of this section. Until a guideline is issued for a specific therapy or discipline, costs are evaluated so that such costs do not exceed what a prudent and cost-conscious buyer would pay for the given service.

(d) *Notice of guidelines to be imposed.* Prior to the beginning of a period to which a guideline will be applied, a notice will be published in the FEDERAL REGISTER establishing the guideline amounts to be applied to each geographical area by type of therapy.

(e) *Additional allowances.* (1) If a therapist supervises other therapists or has administrative responsibility for operating a provider's therapy department, a reasonable allowance may be added to the adjusted hourly salary equivalency amount by the intermediary based on its knowledge of the differential between therapy supervisors' and therapists' salaries in similar provider settings in the area.

(2) If a therapist performing services under arrangements furnishes equipment and supplies used in furnishing therapy services, the guideline amount may be supplemented by the cost of the equipment and supplies, provided the cost does not exceed the amount the provider, as a prudent and cost-conscious buyer, would have been able to include as allowable cost.

(f) *Exceptions.* The following exceptions may be granted but only upon the provider's demonstration that the conditions indicated are present:

(1) *Exception because of unique circumstances or special labor market conditions.* An exception may be granted under this section by the intermediary if a provider demonstrates that the costs for therapy services established by the guideline amounts are inappropriate to a particular provider because of some unique circumstances or special labor market conditions in the area.

(2) *Exception for services furnished by risk-basis HMO providers.* For special rules concerning services furnished to an HMO's enrollees who are Medicare beneficiaries by a provider owned or operated by a risk-basis HMO (see § 417.201(b) of this chapter) or related to a risk-basis HMO by common ownership or control (see § 417.250(c) of this chapter).

(3) *Exception for inpatient hospital services.* Effective with cost reporting periods beginning on or after October 1, 1983, the costs of therapy services furnished under arrangements to a hospital inpatient are excepted from the guidelines issued under this section if such costs are subject to the provisions of § 413.40 or part 412 of this chapter. The intermediary will grant the exception without request from the provider.

(g) *Appeals.* A request by a provider for a hearing on the determination of an intermediary concerning the therapy costs determined to be allowable based on the provisions of this section, including a determination with respect to an exception under paragraph (f) of this section, is made to the intermediary only after submission of its cost report and receipt of the notice of

amount of program reimbursement reflecting such determination, in accordance with the provisions of subpart R of part 405 of this chapter.

[51 FR 34793, Sept. 30, 1986, as amended at 63 FR 5139, Jan. 30, 1998]

§ 413.114 Payment for posthospital SNF care furnished by a swing-bed hospital.

(a) *Purpose and basis.* This section implements section 1883 of the Act, which provides for payment for posthospital SNF care furnished by rural hospitals having a swing-bed approval. Payments to these hospitals for posthospital SNF care furnished in general routine inpatient beds are based on the reasonable cost of posthospital SNF care in accordance with paragraph (c) of this section. Swing-bed hospitals approved after March 31, 1988 with more than 49 beds must meet additional payment requirements as set forth in paragraph (d) of this section.

(b) *Definitions.* For purposes of this section—

Availability date means with respect to a posthospital SNF care patient in a swing-bed hospital, the later of—

(i) Any date on which a bed is available for the patient in a Medicare-participating SNF located within the hospital's geographic region;

(ii) The date that a hospital learns that a bed is available in a Medicare-participating SNF; or

(iii) If the notice is prospective, the date that a bed will become available in a Medicare-participating SNF.

Geographic region means an area that includes the SNFs with which a hospital has traditionally arranged transfers and all other SNFs within the same proximity to the hospital. In the case of a hospital without existing transfer practices upon which to base a determination, the geographic region is an area that includes all the SNFs within 50 miles (as defined in § 412.92(c)(1) of this chapter) of the hospital unless the hospital can demonstrate that the SNFs are inaccessible to its patients. In the event of a dispute as to whether an SNF is within a hospital's geographic region or the SNF is inaccessible to hospital patients, the HCFA Regional Office makes a determination.

Swing-bed hospital means a hospital or CAH participating in Medicare that has an approval from HCFA to provide posthospital SNF care as defined in § 409.20 of this chapter, and meets the requirements specified in § 482.66 or § 485.645 of this chapter, respectively.

(c) *Principle.* The reasonable cost of posthospital SNF care furnished by a swing-bed hospital is determined as follows:

(1) The reasonable cost of routine SNF services is based on the average Medicare rate per patient day for routine services provided in freestanding SNFs in the region where the swing-bed hospital is located. The rates are calculated using the regions as defined in section 1886(d)(2)(D) of the Social Security Act. The rates are based on the most recent year for which settled cost reporting period data are available, increased in a compounded manner, using the increase applicable to the SNF routine cost limits, up to and including the calendar year for which the rates are in effect. If the current Medicare swing-bed rate for routine extended care services furnished by a swing-bed hospital during a calendar year is less than the rate for the prior calendar year, payment is made based on the prior calendar year's rate.

(2) The reasonable cost of ancillary services furnished as posthospital SNF care is determined in the same manner as the reasonable cost of other ancillary services furnished by the hospital in accordance with § 413.55(a)(1).

(d) *Additional requirements*—(1) *General rule.* Prior to Medicare payment being made to a swing-bed hospital with more than 49 beds (but fewer than 100) the following payment requirements must be met:

(i) If there is an available SNF bed in the geographic region, a posthospital SNF care patient must be transferred within 5 days (excluding weekends and holidays) of the availability date, unless the patient's physician certifies within the 5-day period that transfer is not medically appropriate.

(ii) The number of patient days for posthospital SNF care in a cost reporting period does not exceed 15 percent of the product of the number of days in the period and the average number of

licensed beds in the hospital in the period. In those States that do not license their hospital beds, the hospitals must use the total number of hospital beds reported on their most recent Certificate of Need (CON), excluding bassinets. If during the cost reporting period, there is an increase or decrease in the number of ''licensed'' beds, the number of ''licensed'' beds for each part of the period is to be multiplied by the number of days for which that number of ''licensed'' beds was available. After totalling the results, compute 15 percent of the total available ''licensed'' bed days to determine the payment limitation.

(2) *Payment restrictions.* (i) The hospital must not seek payment for posthospital SNF care after the end of the 5 day period (excluding weekends and holidays) beginning on the availability date of a SNF bed unless the patient's physician has certified, within that 5 day period, that the transfer of the patient to the SNF was not medically appropriate.

(ii) The hospital must not seek payment for posthospital SNF care in a cost reporting period to the extent that they exceed 15 percent of the product of the number of days in the period and the average number of licensed beds in the period. In those States that do not license hospital beds, the hospital must use the average number of hospital beds reported on its most recent CON, excluding bassinets.

(3) *Payment exception.* Payment will continue to be made during the cost reporting period in which the 15 percent limit specified in paragraph (d)(1)(ii) of this section is reached for those patients who are receiving posthospital SNF care at the time the hospital reaches the limit.

[51 FR 34793, Sept. 30, 1986, as amended at 54 FR 37274, Sept. 7, 1989; 56 FR 54545, Oct. 22, 1991; 58 FR 30671, May 26, 1993; 61 FR 51616, Oct. 3, 1996; 62 FR 46037, Aug. 29, 1997]

§ 413.118 Payment for facility services related to covered ASC surgical procedures performed in hospitals on an outpatient basis.

(a) *Basis and scope.* This section implements section 1833(a)(4) and (i)(3) of the Act and establishes the method for determining Medicare payments for services related to covered ambulatory surgical center (ASC) procedures performed in a hospital on an outpatient basis. It does not apply to services furnished by an ASC operated by a hospital that has an agreement with HCFA to be paid in accordance with § 416.30 of this chapter. (For regulations governing ASCs see part 416 of this chapter.)

(b) *Definitions.* For purposes of this section—

Facility services are those items and services, as specified in § 416.61 of this chapter, that are furnished by a hospital on an outpatient basis in connection with covered ASC surgical procedures, as described in § 416.65 of this chapter.

Standard overhead amount means an amount equal to the prospectively determined payment rate that would be paid for the procedure if it had been furnished by an ASC in the same geographic area.

(c) *Payment principle.* The aggregate amount of payments for facility services, furnished in a hospital on an outpatient basis, that are related to covered ASC surgical procedures (covered under § 416.65 of this chapter) is equal to the lesser of—

(1) The hospital's reasonable cost or customary charges, as determined in accordance with § 413.13, reduced by deductibles and coinsurance; or

(2) The blended payment amount as described in paragraph (d) of this section, which is based on hospital-specific cost and charge data and rates paid to free-standing ASCs.

(d) *Blended payment amount.* (1) For cost reporting periods beginning on or after October 1, 1987 but before October 1, 1988, the blended payment amount is equal to the sum of—

(i) 75 percent of the hospital-specific amount (the lesser of the hospital's reasonable cost or customary charges, reduced by deductibles and coinsurance); and

(ii) 25 percent of the ASC payment amount (that is, 80 percent of the result obtained by subtracting the deductibles from the sum of the standard overhead amounts.)

(2) For the period of time beginning with the first day of a hospital's cost reporting period that begins on or after

October 1, 1988 and ends on December 31, 1990, the blended payment amount is equal to 50 percent of the hospital-specific amount and 50 percent of the ASC payment amount.

(3) For portions of cost reporting periods beginning on or after January 1, 1991, the blended payment amount is equal to 42 percent of the hospital-specific amount and 58 percent of the ASC payment amount.

(4) For cost reporting periods beginning on or after October 1, 1988 and before January 1, 1995, the blended payment amount is equal to the sum of 75 percent of the hospital-specific amount and 25 percent of the ASC payment amount for a hospital that makes an application to its fiscal intermediary and meets the following requirements.

(i) More than 60 percent of the hospital's inpatient hospital discharges, as described in § 412.60 of this chapter, occurring during its cost reporting period beginning on or after October 1, 1986 and before October 1, 1987, are classified in diagnosis related groups 36 through 74.

(ii) During its cost reporting period beginning on or after October 1, 1986 and before October 1, 1987, more than 30 percent of the hospital's total revenues is derived from outpatient services.

(e) *Aggregation of cost, charges, and the blended amount.* For purposes of determining the correct payment amount under paragraphs (c) and (d) of this section, all reasonable costs and customary charges attributable to facility services furnished during a cost reporting period are aggregated and treated separately from the reasonable costs and customary charges attributable to all other services furnished in the hospital.

[52 FR 36773, Oct. 1, 1987; 52 FR 37715, Oct. 8, 1987, as amended at 55 FR 33699, Aug. 17, 1990; 55 FR 34797, Aug. 24, 1990; 57 FR 36017, Aug. 12, 1992; 57 FR 45113, Sept. 30, 1992]

§ 413.122 Payment for hospital outpatient radiology services and other diagnostic procedures.

(a) *Basis and purpose.* (1) This section implements section 1833(n) of the Act and establishes the method for determining Medicare payments for radiology services and other diagnostic procedures performed by a hospital on an outpatient basis.

(2) For purposes of this section—

(i) Radiology services include diagnostic and therapeutic radiology, nuclear medicine, CAT scan procedures, magnetic resonance imaging, ultrasound and other imaging services; and

(ii) Other diagnostic procedures are those identified by HCFA, and do not include diagnostic radiology procedures or diagnostic laboratory tests.

(b) *Payment for hospital outpatient radiology services.* (1) The aggregate payment for hospital outpatient radiology services furnished on or after October 1, 1988 is equal to the lesser of the following:

(i) The hospital's reasonable cost or customary charges, as determined in accordance with § 413.13, reduced by the applicable Part B annual deductible and coinsurance amounts.

(ii) The blended payment amount described in paragraph (b)(2) of this section.

(2) The blended payment amount for hospital outpatient radiology services furnished on or after October 1, 1988, but before October 1, 1989, is equal to the sum of—

(i) 65 percent of the hospital-specific amount (the hospital's reasonable cost or customary charges, whichever is less, reduced by the applicable Part B annual deductible and coinsurance amounts); and

(ii) 35 percent of a prevailing charge or fee schedule amount that is calculated as 80 percent of the amount determined by subtracting the applicable Part B annual deductible from 62 percent of the prevailing charges (or for services furnished on or after January 1, 1989, the fee schedule amount established) for the same services when furnished by participating physicians in their offices in the same locality.

(3) For hospital outpatient radiology services furnished on or after October 1, 1989, the blended payment amount is equal to the sum of 50 percent of the hospital-specific amount and 50 percent of the fee schedule amount.

(4) For hospital outpatient radiology services furnished on or after January 1, 1991, the blended payment amount is equal to the sum of 42 percent of the

hospital-specific amount and 58 percent of the fee schedule amount.

(c) *Payment for other diagnostic procedures.* (1) The aggregate payment for other diagnostic procedures performed by a hospital on an outpatient basis on or after October 1, 1989 is equal to the lesser of the following:

(i) The hospital's reasonable cost or customary charges, as determined in accordance with § 414.13, reduced by the applicable Part B annual deductible and coinsurance amounts.

(ii) The blended payment described in paragraph (c)(2) of this section.

(2) The blended payment amount for other diagnostic procedures furnished on or after October 1, 1989, but before October 1, 1990, is equal to the sum of—

(i) 65 percent of the hospital-specific amount (the hospital's reasonable cost or customary charges, whichever is less, reduced by the applicable Part B annual deductible and coinsurance amounts); and

(ii) 35 percent of a prevailing charge amount that is calculated as 80 percent of the amount determined by subtracting the applicable Part B annual deductible from 42 percent of the prevailing charges for the same services furnished by participating physicians in their offices in the same locality.

(3) For other diagnostic procedures performed by a hospital on or after October 1, 1990, the blended payment is equal to 50 percent of the hospital-specific amount and 50 percent of the prevailing charge amount.

[56 FR 8842, Mar. 1, 1991, as amended at 57 FR 36017, Aug. 12, 1992]

§ 413.123 Payment for screening mammography performed by hospitals on an outpatient basis.

(a) *Basis and scope.* This section implements section 1834(c)(1)(C) of the Act and establishes the method for determining Medicare payment for screening mammographies performed by hospitals.

(b) *Payment to hospitals for outpatient services.* Payment to hospitals for screening mammography services performed on an outpatient basis is determined in accordance with the technical component billing requirements in § 405.534(d) of this chapter.

[55 FR 53522, Dec. 31, 1990, as amended at 59 FR 49834, Sept. 30, 1994]

§ 413.124 Reduction to hospital outpatient operating costs.

(a) Except for sole community hospitals, as defined in § 412.92, and critical access hospitals, the reasonable costs of outpatient hospital services (other than capital-related costs of such services) are reduced by 5.8 percent for services rendered during portions of cost reporting periods occurring on or after October 1, 1990, and before October 1, 1998.

(b) For purposes of determining the blended payment amounts of ambulatory surgical center approved surgical procedures performed in the hospital outpatient setting under § 413.118 and hospital outpatient radiology services and other diagnostic procedures under § 413.122, the reduction is applicable only to the hospital-specific portion of the blended payment amounts.

[57 FR 36017, Aug. 12, 1992, as amended at 59 FR 26960, May 25, 1994; 62 FR 46037, Aug. 29, 1997]

§ 413.125 Payment for home health agency services.

(a) For additional rules on the allowability of certain costs incurred by home health agencies, see §§ 409.46 and 409.49(b) of this chapter.

(b) The reasonable cost of outpatient rehabilitation services furnished by a home health agency to homebound patients who are not entitled to home health benefits may not exceed the amounts payable under the physician fee schedule for comparable services effective January 1, 1999.

[59 FR 65497, Dec. 20, 1994, as amended at 63 FR 58910, Nov. 2, 1998]

Subpart G—Capital-Related Costs

§ 413.130 Introduction to capital-related costs.

(a) *General rule.* Capital-related costs and an allowance for return on equity are limited to the following:

(1) Net depreciation expense as determined under §§ 413.134, 413.144, and

413.149, adjusted by gains and losses realized from the disposal of depreciable assets under § 413.134(f).

(2) Taxes on land or depreciable assets used for patient care.

(3) Leases and rentals, including license and royalty fees, for the use of depreciable assets or land, as described in paragraph (b) of this section.

(4) The costs of betterments and improvements as described in paragraph (c) of this section.

(5) The costs of minor equipment that are capitalized, rather than expensed, as described in paragraph (d) of this section.

(6) Insurance expense on depreciable assets, as described in paragraph (e) of this section.

(7) Interest expense as determined under § 413.153, subject to the qualifications of paragraph (f) of this section.

(8) For certain proprietary providers, return on equity capital, as determined under § 413.157.

(9) The capital-related costs of related organizations (as described in § 413.17), as determined in accordance with paragraph (g) of this section.

(10) Debt issuance costs, debt discounts, and debt redemption costs, if the associated debt was incurred to acquire land or depreciable assets used for patient care or to refinance existing debt for which the original purpose was to acquire land or depreciable assets used for patient care.

(11) The apportionment of the capital-related costs of jointly owned assets among the owners must be on a basis that reflects the relative use by each owner, rather than the ownership share or the amount of time the asset is located at each owners site.

(b) *Leases and rentals.* (1) Subject to the qualifications of paragraphs (b) (2), (4), (5), and (8) of this section, leases and rentals, including licenses and royalty fees, are includable in capital-related costs if they relate to the use of assets that would be depreciable if the provider owned them outright or they relate to land, which is neither depreciable nor amortizable if owned outright. The terms *''leases''* and *''rentals of assets''* signify that a provider has possession, use, and enjoyment of the assets.

(2) For sale and leaseback agreements for hospitals and SNFs entered into before October 23, 1992 and for sale and leaseback agreements for other providers entered into at any time, a provider may include incurred rental charges in its capital-related costs, as specified in a sale and leaseback agreement with a nonrelated purchaser (including shared service organizations not related within the meaning of § 413.17) involving plant facilities or equipment only if the following conditions are met:

(i) The rental charges are reasonable based on the following—

(A) Consideration of rental charges of comparable facilities and market conditions in the area;

(B) The type, expected life, condition, and value of the facilities or equipment rented; and

(C) Other provisions of the rental agreements.

(ii) Adequate alternative facilities or equipment that would serve the purpose are not or were not available at lower cost.

(iii) The leasing was based on economic and technical considerations.

(3) If the conditions of paragraph (b)(2) of this section are not met, the amount a provider may include in its capital-related costs as rental or lease expense under a sale and leaseback agreement may not exceed the amount that the provider would have included in its capital-related costs had the provider retained legal title to the facilities or equipment, such as interest on mortgage, taxes, depreciation, and insurance costs.

(4) For sale and leaseback agreements for hospitals and SNFs entered into on or after October 23, 1992, the amount a provider may include in its capital-related costs as rental or lease expense may not exceed the amount that the provider would have included in its capital-related costs had the provider retained legal title to the facilities or equipment, such as interest expense on mortgages, taxes, depreciation, and insurance costs (the costs of ownership). This limitation applies both on an annual basis and over the useful life of the asset.

(i) If in the early years of the lease, the annual rental or lease costs are less

than the annual costs of ownership, but in the later years of the lease the annual rental or lease costs are more than the annual costs of ownership, in the years that the annual rental or lease costs are more than the annual costs of ownership, the provider may include in capital-related costs annually the actual amount of rental or lease costs. The aggregate rental or lease costs included in capital-related costs may not exceed the aggregate costs of ownership that would have been included in capital-related costs over the useful life of the asset had the provider retained legal title to the asset.

(ii) If in the early years of the lease, the annual rental or lease costs exceed the annual costs of ownership, but in the later years of the lease the annual rental or lease costs are less than the annual costs of ownership, the provider may carry forward amounts of rental or lease costs that were not included in capital-related costs in the early years of the lease due to the costs of ownership limitation, and include these amounts in capital-related costs in the years of the lease when the annual rental or lease costs are less than the annual costs of ownership.

(iii) In any given year the amount of actual annual rental or lease costs plus the amount carried forward to that year may not exceed the amount of the costs of ownership for that year.

(iv) In the aggregate, the amount of rental or lease costs included in capital-related costs may not exceed the amount of the costs of ownership that the provider could have included in capital-related costs had the provider retained legal title to the asset.

(5) For lease purchase transactions entered into before October 23, 1992, a lease that meets the following conditions establishes a virtual purchase:

(i) The rental charge exceeds rental charges of comparable facilities or equipment in the area.

(ii) The term of the lease is less than the useful life of the facilities or equipment.

(iii) The provider has the option to renew the lease at a significantly reduced rental, or the provider has the right to purchase the facilities or equipment at a price that appears to be significantly less than what the fair market value of the facilities or equipment would be at the time acquisition by the provider is permitted.

(6)(i) If a lease is a virtual purchase under paragraph (b)(5) of this section, the rental charge is includable in capital-related costs only to the extent that it does not exceed the amount that the provider would have included in capital-related costs if it had legal title to the asset (the cost of ownership), such as straight-line depreciation, insurance, and interest. A provider may not include in its capital-related costs accelerated depreciation in this situation.

(ii) The difference between the amount of rent paid and the amount of rent allowed as capital-related costs is considered a deferred charge and is capitalized as part of the historical cost of the asset when the asset is purchased.

(iii) If an asset is returned to the owner, instead of being purchased, the deferred charge may be included in capital-related costs in the year the asset is returned.

(iv) If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase still exists, the deferred charge may be included in capital-related costs to the extent of increasing the reduced rental to an amount not in excess of the cost of ownership.

(v) If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase no longer exists, the deferred charge may be included in the capital-related costs to the extent of increasing the reduced rental to a fair rental value.

(7) Amounts included in lease or rental payments for repair or maintenance agreements are excluded from capital-related costs. If no amount is identified in the lease or rental agreement for maintenance, the entire lease payment is considered a capital-related cost subject to the provisions of paragraph (b)(1) of this section.

(8) For lease purchase transactions entered into on or after October 23, 1992, a lease that meets any one of the following conditions establishes a virtual purchase:

(i) The lease transfers title of the facilities or equipment to the lessee during the lease term.

(ii) The lease contains a bargain purchase option.

(iii) The lease term is at least 75 percent of the useful life of the facilities or equipment. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment.

(iv) The present value of the minimum lease payments (payments to be made during the lease term including bargain purchase option, guaranteed residual value, and penalties for failure to renew) equals at least 90 percent of the fair market value of the leased property. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment. Present value is computed using the lessee's incremental borrowing rate, unless the interest rate implicit in the lease is known and is less than the lessee's incremental borrowing rate, in which case the interest rate implicit in the lease is used.

(9)(i) If a lease establishes a virtual purchase under paragraph (b)(8) of this section, the rental charge is includable in capital-related costs to the extent that it does not exceed the amount that the provider would have included in capital-related costs if it had legal title to the asset (the cost of ownership). The cost of ownership includes straight-line depreciation, insurance, and interest. For purposes of computing the limitation on allowable rental cost in this paragraph, a provider may not include accelerated depreciation.

(ii) The difference between the amount of rent paid and the amount of rent allowed as capital-related costs is considered a deferred charge and is capitalized as part of the historical cost of the asset when the asset is purchased.

(iii) If an asset is returned to the owner instead of being purchased, the deferred charge may be included in capital-related costs in the year the asset is returned.

(iv) If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase still exists, the deferred charge may be included in capital-related costs to the extent of increasing the reduced rental to an amount not in excess of the cost of ownership.

(v) If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase no longer exists, the deferred charge may be included in capital-related costs to the extent of increasing the reduced rental to a fair rental value.

(vi) If the lessee becomes the owner of the leased asset (either by operation of the lease or by other means), the amount considered as depreciation, for the purpose of having computed the limitation on rental charges in paragraph (b)(9)(i) of this section, must be used in calculating the limitation on adjustments for the purpose of determining any gain or loss under § 413.134(f) upon disposal of an asset.

(c) *Betterments and improvements.* (1) Betterments and improvements are changes which extend the estimated useful life of an asset at least two years beyond its original estimated useful life, or increase the productivity of an asset significantly over its original productivity.

(2) A provider must capitalize and prorate the costs of betterments and improvements over the remaining estimated useful life of the asset, as modified by the betterment or improvement.

(d) *Minor equipment.* A provider must include in its capital-related costs the costs of minor equipment that are capitalized rather than charged off to expense if—

(1) The net book value of minor equipment at the time the provider enters the program is prorated over three years (that is, one-third of the net book value is written off each year), and new purchases are also prorated over a 3-year period; or

(2) The cost of minor equipment is prorated over their actual useful lives.

(e) *Insurance.* (1) A provider must include in its capital-related costs the costs of insurance on depreciable assets used for patient care or insurance that provides for the payment of capital-related costs during business interruption.

(2) If an insurance policy also provides protection for other than the replacement of depreciable assets or to pay capital-related costs in the case of business interruption insurance, only that portion of the premium related to the replacement of depreciable assets or to pay capital-related costs in the case of business interruption insurance is includable in capital-related costs.

(f) *Debt premiums and debt discounts.* Debt premiums or debt discount are applied as adjustments to capital-related costs if the associated debt is incurred for acquiring land or depreciable assets used for patient care or for refinancing existing debt for which the original purpose was to acquire land or depreciable assets used for patient care.

(g) *Interest expense.* (1) A provider must include in its capital-related costs interest expense, as described in § 413.153, if such expense is incurred in—

(i) Acquiring land or depreciable assets (either through purchase or lease) used for patient care; or

(ii) Refinancing existing debt, if the original purpose of the refinanced debt was to acquire land or depreciable assets used for patient care.

(2) If investment income offset is required under § 413.153(b)(2)(iii), only that portion of investment income that bears the same relationship to total investment income, as the portion of capital-related interest expense bears to total interest expense, is offset against capital-related costs.

(h) *Costs of supplying organizations*—(1) *Supplying organizations related to the provider.* (i) If the supplying organization is related to the provider within the meaning of § 413.17, except as provided in paragraph (g)(1)(ii) of this section, a provider's capital-related costs include the capital-related costs of the supplying organization.

(ii) If the costs of the services, facilities or supplies being furnished exceed the open market price, or if the provisions of § 413.17(d) apply, no part of the cost to the provider of the services, facilities, or supplies are considered capital-related costs, unless the services, facilities, or supplies would otherwise be considered capital-related.

(2) *Supplying organizations not related to the provider.* If the supplying organization is not related to the provider within the meaning of § 413.17, no part of the charge to the provider may be considered a capital-related cost (unless the services, facilities, or supplies are capital-related in nature) unless—

(i) The capital-related equipment is leased or rented (as described in paragraph (b) of this section) by the provider;

(ii) The capital-related equipment is located on the provider's premises, or is located offsite and is on real estate owned, leased or rented by the provider; and

(iii) The capital-related portion of the charge is separately specified in the charge to the provider.

(i) *Costs excluded from capital-related costs.* The following costs are not capital-related costs. To the extent that they are allowable, they must be included in determining each provider's operating costs:

(1) Costs incurred for the repair or maintenance of equipment or facilities.

(2) Amounts included in rentals or lease payments for repair or maintenance agreements.

(3) Interest expense incurred to borrow working capital (for operating expenses).

(4) General liability insurance or any other form of insurance to provide protection other than for the replacement of depreciable assets or to pay capital-related costs in the case of business interruption.

(5) Taxes other than those assessed on the basis of some valuation of land or depreciable assets used for patient care. (Taxes not related to patient care, such as income taxes, are not allowable, and are therefore not included among either capital-related or operating costs.)

(6) The costs of minor equipment that are charged off to expense rather than capitalized as described in paragraph (d) of this section.

(7) The costs incurred for maintenance and repair insurance agreements (commonly referred to as maintenance agreements).

(j) *Reduction to capital-related costs.* (1) Except for sole community hospitals and critical access hospitals, the amount of capital-related costs of all hospital outpatient services is reduced by—

(i) 15 percent for portions of cost reporting periods occurring on or after October 1, 1989, through September 30, 1991; and

(ii) 10 percent for portions of cost reporting periods occurring on or after October 1, 1991, through September 30, 1998.

(2) For purposes of determining the blended payment amounts for hospital outpatient services under §413.118 and §413.122, the reduction is applicable only to the hospital-specific portion of the blended amounts.

[51 FR 34793, Sept. 30, 1986, as amended at 52 FR 21225, June 4, 1987; 56 FR 43456, Aug. 30, 1991; 57 FR 3017, Jan. 27, 1992; 57 FR 36017, Aug. 12, 1992; 57 FR 43917, Sept. 23, 1992; 58 FR 17528, Apr. 5, 1993; 59 FR 26960, May 25, 1994; 62 FR 46037, Aug. 29, 1997]

§413.134 Depreciation: Allowance for depreciation based on asset costs.

(a) *Principle.* An appropriate allowance for depreciation on buildings and equipment used in the provision of patient care is an allowable cost. The depreciation must be—

(1) Identifiable and recorded in the provider's accounting records;

(2) Based on the historical cost of the asset, except as specified in paragraph (j) of this section regarding donated assets; and

(3) Prorated over the estimated useful life of the asset using—

(i) The straight-line method; or

(ii) Accelerated depreciation under a declining balance method (not to exceed double the straight-line rate) or the sum-of-the-years' digits method in the following situations:

(A) Depreciable assets for which accelerated depreciation was used for Medicare purposes before August 1, 1970, including those assets for which a timely request to change from straight-line depreciation to accelerated depreciation was received by an intermediary before August 1, 1970;

(B) Depreciable assets acquired before August 1, 1970, if no election to use straight-line or accelerated depreciation was in effect on August 1, 1970, and the provider was participating in the program on August 1, 1970;

(C) Depreciable assets of a provider if construction of such depreciable asset began before February 5, 1970, and the provider was participating in the program on February 5, 1970; or

(D) Depreciable assets of a provider if a valid written contract was entered into by a provider participating in the program before February 5, 1970, for construction, acquisition, or for the permanent financing thereof, and such contract was binding on a provider on February 5, 1970, and at all times thereafter; or

(iii) A declining balance method, not to exceed 150 percent of the straight-line rate, for a depreciable asset acquired after July 31, 1970; however, this declining balance method may be used only if the cash flow from depreciation on the total assets of the institution during the reporting period, including straight-line depreciation on the assets in question, is insufficient (assuming funding of available capital not required currently for amortization and assuming reasonable interest income on such funds) to supply the funds required to meet the reasonable principal amortization schedules on the capital debts related to the provider's total depreciable assets. For each depreciable asset for which a provider requests authorization to use a declining balance method for Medicare reimbursement purposes, but not to exceed 150 percent of the straight-line rate, the provider must demonstrate to the intermediary's satisfaction that the required cash flow need exists. For each depreciable asset in which a provider justifies the use of accelerated depreciation, the intermediary must give written approval for the use of a depreciation method other than straight-line before basing any interim payment on this accelerated depreciation or making its reasonable cost determination which includes an allowance for such depreciation.

(b) *General rules*—(1) *Historical cost.* Historical cost is the cost incurred by the present owner in acquiring the asset.

(i) *All providers*—(A) *Depreciable assets acquired after July 31, 1970 and before December 1, 1997.* For depreciable assets acquired after July 31, 1970 and before December 1, 1997, and for a hospital or an SNF, acquired before July 18, 1984, the historical cost may not exceed the

lower of current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of the purchase or the fair market value of the asset at the time of its purchase.

(B) *Depreciable assets acquired on or after December 1, 1997.* For depreciable assets acquired on or after December 1, 1997, the historical cost of the asset that will be recognized under this program must not exceed the historical cost less depreciation allowed to the owner of record as of August 5, 1997 (or if an asset did not exist as of August 5, 1997, the first owner of record after August 5, 1997). For this paragraph (b)(1)(i)(B), the following apply:

(*1*) An asset that was not in existence as of August 5, 1997 includes an asset that physically existed but was not owned by a provider participating in the Medicare program as of that date.

(*2*) The acquisition cost to the owner of record is subject to the limitation on historical costs described in paragraphs (g) (1), (2), and (3) of this section, and is reduced by any depreciation taken by the owner of record. The limitation on historical cost is also applied to the purchase of land, which is a capital asset that is neither depreciable nor amortizable under any circumstances. (See §§ 413.153(d) and 413.157(b) for application of the limitation to the cost of land for purposes of determining the allowable interest expense.)

(*3*) Acquisition cost to the owner of record includes the costs of betterment or improvements that extend the estimated useful life of an asset at least 2 years beyond its original estimated useful life or that increase the productivity of an asset significantly over its original productivity.

(*4*) For assets acquired prior to a provider's entrance into the Medicare program, the acquisition cost to the owner of record is the historical cost when acquired, rather than when the provider entered the program.

(*5*) For assets subject to the optional depreciation allowance as described in § 413.139, the acquisition cost to the owner of record is the historical cost established for those assets when the provider changed to actual depreciation as described in § 413.139(e). If the provider did not change to actual depreciation, as described in § 413.139(e), for optional allowance assets, the acquisition cost to the owner of record is based on the provider's recorded historical cost of the asset when acquired. If the provider has no historical cost records for optional allowance assets, the acquisition cost to the owner of record is established by appraisal.

(*6*) The historical cost of an asset acquired on or after July 18, 1984 may not include costs attributable to the negotiation or settlement of the sale or purchase (by acquisition, merger, or consolidation) of any capital asset for which any payment was previously made under the Medicare program. The costs to be excluded include, but are not limited to, appraisal costs (except those incurred at the request of the intermediary under paragraph (f)(2)(iv) of this section), legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies.

(ii) *Hospitals and SNFs only.* (A) For assets acquired on or after July 18, 1984 and before December 1, 1997 and not subject to an enforceable agreement entered into before July 18, 1984, historical cost may not exceed the lowest of the following:

(*1*) The allowable acquisition cost of the asset to the owner of record as of July 18, 1984 (or, in the case of an asset not in existence as of July 18, 1984, the first owner of record of the asset after that date);

(*2*) The acquisition cost of the asset to the new owner; or

(*3*) The fair market value of the asset on the date of acquisition.

(B) For purposes of applying paragraph (b)(1)(ii)(A) of this section, an asset not in existence as of July 18, 1984 includes any asset that physically existed, but was not owned by a hospital or SNF participating in the Medicare program as of July 18, 1984.

(C) The acquisition cost to the owner of record is subject to any limitation on historical costs described in paragraphs (b)(1)(i) or (g)(1) and (2) of this section, and is not reduced by any depreciation taken by the owner of record. This limitation on historical cost is also applied to the purchase of land, a capital asset that is neither depreciable nor amortizable under any circumstances. (See §§ 413.153(d) and

413.157(b) for application of the limitation to the cost of land for purposes of determining allowable interest expense and return on equity capital or proprietary providers.)

(D) Acquisition cost to the owner of record includes the costs of betterments or improvements that extend the estimated useful life of an asset at least two years beyond its original estimated useful life or increase the productivity of an asset significantly over its original productivity.

(E) For assets acquired prior to a hospital's or SNF's entrance into the Medicare program, the acquisition cost to the owner of record is the historical cost of the asset when acquired, rather than when the hospital or SNF entered the program.

(F) For assets subject to the optional depreciation allowance as described in § 413.139, the acquisition cost to the owner of record is the historical cost established for those assets when the hospital or SNF changed to actual depreciation as described in § 413.139(e). If the hospital or SNF did not change to actual depreciation, as described in § 413.139(e), for optional allowance assets, the acquisition cost to the owner of record is established by reference to the hospital's or SNF's recorded historical cost of the asset when acquired. If the hospital or SNF has no historical cost records for optional allowance assets, the acquisition cost to the owner of record is established by appraisal.

(G) The historical cost of an asset acquired on or after July 18, 1984 may not include costs attributable to the negotiation or settlement of the sale or purchase (by acquisition, merger, or consolidation) of any capital asset for which any payment was previously made under the Medicare program. The costs to be excluded include, but are not limited to, appraisal costs (except those incurred at the request of the intermediary under paragraph (f)(2)(iv) of this section), legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies.

(iii) *Hospital-based providers other than SNFs and SNF-based providers.* For changes of ownership that involve assets of a hospital-based provider other than a SNF, or assets of a SNF-based provider, the provisions of paragraph (b)(1)(ii) of this section are not applicable. A reasonable allocation of the purchase price must be made, so that the hospital-based provider other than a SNF, or a SNF-based provider, is not affected by the limitations described in paragraph (b)(1)(ii) of this section. The historical cost of assets of providers other than hospitals and SNFs is governed by paragraph (b)(1)(i) of this section.

(2) *Fair market value.* Fair market value is the price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition. Usually the fair market price is the price that bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition.

(3) *The straight-line method.* Under the straight-line method of depreciation, the cost or other basis (for example, fair market value in the case of donated assets) of the asset, less its estimated salvage value, if any, is determined first. Then this amount is distributed in equal amounts over the period of the estimated useful life of the asset.

(4) *Declining balance method.* Under the declining balance method, the annual depreciation allowance is computed by multiplying the undepreciated cost of the asset each year by a uniform rate up to double the straight-line rate or 150 percent, as the case may be (see paragraph (a)(3) of this section for limitations on use of accelerated methods of depreciation).

(5) *Sum-of-the-years' digits method.* Under the sum-of-the-years' digits method, the annual depreciation allowance is computed by multiplying the depreciable cost basis (cost less salvage value) by a constantly decreasing fraction. The numerator of the fraction is represented by the remaining years of useful life of the asset at the beginning of each year, and the denominator is always represented by the sum of the years' digits of useful life at the time of acquisition.

(6) *Current reproduction cost.* Current reproduction cost is the cost at current prices, in a particular locality or market area, of reproducing an item of property or a group of assets. Where

depreciable assets are concerned, this means the reasonable cost to have built, reproduce in kind, or, in the case of equipment or similar assets, to purchase in the competitive market.

(7) *Useful life.* The estimated useful life of a depreciable asset is its normal operating or service life to the provider, subject to the provisions in paragraph (b)(7)(i) of this section. Factors to be considered in determining useful life include normal wear and tear; obsolescence due to normal economic and technological changes; climatic and other local conditions; and the provider's policy for repairs and replacement.

(i) *Initial selection of useful life.* In selecting a proper useful life for computing depreciation under the Medicare program, providers must use the useful life guidelines published by HCFA. If HCFA has not published applicable useful life guidelines, providers must use—

(A) The edition of the American Hospital Association useful life guidelines, as specified in HCFA Medicare program manuals; or

(B) A different useful life specifically requested by the provider and approved by the intermediary. A different useful life may be approved by the intermediary if the provider's request is properly supported by acceptable factors that affect the determination of useful life. However, such factors as an expected early sale, retirement, demolition or abandonment of an asset, or termination of the provider from the Medicare program may not be used.

(ii) *Application of guidelines.* The provisions concerning the selection of useful life guidelines described in paragraph (b)(7)(i) of this section apply to assets acquired on or after January 1, 1981. For assets acquired before January 1, 1981, providers must use the useful life guidelines published by the American Hospital Association in its 1973 edition of *Chart of Accounts for Hospitals,* or those published by the Internal Revenue Service, or those approved for use by intermediaries as provided in paragraph (b)(7)(i)(B) of this section.

(iii) *Changing useful life.* A change in the estimated useful life may be made if clear and convincing evidence justifies a redetermination of the useful life used by the provider. Such a change must be approved by the intermediary in writing, and the factors cited in paragraphs (b)(7) and (b)(7)(i) of this section are applicable in making such redeterminations of useful life. If the request is approved, the change is effective with the reporting period immediately following the period in which the provider's request is submitted for approval.

(8) *Donated asset.* An asset is considered donated when the provider acquires the asset without making payment in the form of cash, new debt, assumed debt, property or services. Except as provided in paragraph (j)(3) of this section, if a provider makes payment in any form to acquire an asset, the payment is considered the purchase price for the purpose of determining allowable historical cost.

(9) *Net book value.* The net book value of an asset is the depreciable basis used for the Medicare program by the asset's last participating owner less depreciation recognized under the Medicare program.

(c) *Recording of depreciation.* Appropriate recording of depreciation includes the identification of the depreciable assets in use, the assets' historical costs, the assets' dates of acquisition, the method of depreciation, estimated useful lives, and the assets' accumulated depreciation.

(d) *Depreciation methods*—(1) *General.* Proration of the cost of an asset over its useful life is allowed on the straight-line method, or, when permitted under paragraph (a)(3) of this section, the declining balance or the sum-of-the-years' digits methods. One method may be used on a single asset or group of assets and another method on others. In applying the declining balance or sum-of-the-years' digits method to an asset that is not new, the undepreciated cost of the asset is treated as the cost of a new asset in computing depreciation.

(2) *Change in method.* Prior to August 1, 1970, a provider may change from the straight-line method to an accelerated method or vice versa, upon advance approval from the intermediary on a prospective basis with the request being made before the end of the first month of the prospective reporting period.

Only one such change with respect to a particular asset may be made by a provider. Effective with August 1, 1970, a provider may only change from an accelerated method or optional method (see § 413.139) to the straight-line method. Such a change may be made without intermediary approval and the basis for depreciation is the undepreciated cost reduced by the salvage value. Thereafter, once straight-line depreciation is selected for a particular asset, an accelerated method may not be established for that asset.

(3) *Recovery of accelerated depreciation*—(i) *General.* If a provider who has used an accelerated method of depreciation for any of its assets terminates participation in the program, or if the Medicare proportion of its allowable costs decreases so that cumulatively substantially more depreciation was paid than would have been paid using the straight-line method of depreciation, the excess of reimbursable cost determined by using accelerated depreciation methods and paid under the program over the reimbursable cost that would have been determined and paid under the program by using the straight-line method of depreciation, will be recovered as an offset to current reimbursement due or, if the provider has terminated participation in the program, as an overpayment. In this determination of excess payment, recognition will be given to the effects the adjustment to straight-line depreciation would have on the return on equity capital and on the allowance in lieu of specific recognition of other costs in the respective years.

(ii) *Transaction between related organizations*—(A) *General.* If the termination of the provider agreement is due to a change in provider ownership, as defined in § 489.18 of this chapter, resulting from a transaction between related organizations, as defined in § 413.17, and the criteria in paragraph (b) of this section are met, the excess of reimbursable cost, as determined in paragraph (d)(3)(i) of this section may not be recovered if there is a continuation of participation by the facility in the Medicare program.

(B) *Criteria.* The following criteria must be met if the recovery of excess reimbursable cost is not to be made:

(*1*) The termination of the provider agreement is due to a change in ownership of the provider resulting from a transaction between related organizations.

(*2*) The successor provider continues to participate in the Medicare program.

(*3*) Control and the extent of the financial interest of the owners of the provider before and after the termination remain the same; that is, the successor owners acquire the same percentage of control or financial investment as the transferors had.

(*4*) All assets and liabilities of the terminated provider are transferred to the related successor participating provider.

(C) *Effect of transaction.* In transactions meeting the criteria specified in paragraph (d)(3)(ii)(B) of this section, the provision concerning recovery of excess reimbursable cost (§ 413.134(d)(3)(i)) is not applied, and the transaction is treated as follows:

(*1*) The successor provider must record the historical cost and accumulated depreciation and the method of depreciation recognized under the Medicare program, and these are considered as incurred by the successor provider for Medicare purposes.

(*2*) The Medicare program's utilization of the terminated provider is considered as having been incurred by the successor provider for Medicare purposes.

(*3*) The equity capital of the terminated provider as of the closing of its final cost reporting period must be wholly contained in the equity capital of the successor provider as of the beginning of its first cost reporting period.

(e) *Funding of depreciation.* Although funding of depreciation is not required, it is strongly recommended that providers use this mechanism as a means of conserving funds for replacement of depreciable assets. Funded depreciation account funds must be placed in readily marketable investments of the type that assures the availability and conservation of the funds. Additions to the funded depreciation account must remain in the account for at least 6 months to be considered valid funding transactions.

(1) *Incentive.* As an incentive for funding, investment income on funded depreciation is not treated as a reduction of allowable interest expense provided such investment income is deposited in, and becomes part of, the funded depreciation account at the time of receipt by the provider. Investment income earned on deposits before the 6-month period elapses are not offset unless the deposits are withdrawn for an improper purpose during this period. If a provider transfers assets of the funded depreciation account to a related organization (for example, pooling of several chain organization providers' funded depreciation accounts at the chain home office for investment purposes), these assets shall be treated as the provider's funds and are subject to all the requirements specified in paragraph (e) of this section.

(2) *Availability of funded depreciation.* (i) HCFA considers funded depreciation available for use in the acquisition or replacement of depreciable assets related to patient care unless the funded depreciation funds have been committed by contract for the acquisition of depreciable assets related to the furnishing of patient care or for other capital purposes related to patient care.

(ii) Borrowing for a purpose for which funded depreciation account funds should have been used makes the borrowing unnecessary to the extent that funded depreciation account funds were available at the time of the borrowing. Available funds in the funded depreciation account, to the extent of the unnecessary borrowing, are called ''tainted'' funds. Interest expense incurred on borrowing for a capital purpose is not an allowable cost to the extent that funded depreciation account funds were available at the time of the borrowing.

(iii) A provider can remove the ''unnecessary'' characterization of borrowing, and thereby cure tainted funded depreciation, by using the tainted funds for a proper purpose described in paragraph (e)(3)(i) of this section. However, any funded depreciation that existed at the time of the unnecessary borrowing and is not classified as tainted must be used before any of the tainted funds.

(iv) When only a portion of the borrowing is considered unnecessary under paragraph (e)(2)(ii) of this section, subsequent repayments of such borrowing from general funds are applied first to the allowable portion of the borrowing and then, when all of the allowable borrowing is repaid, to the unallowable portion of the borrowing. When funds from the funded depreciation account are used for the repayment of the unnecessary borrowing, an equivalent amount of tainted funds is cured without regard to the provisions of paragraphs (e)(2)(ii) and (e)(3)(i)(C) of this section. Similarly, where general funds are used to pay for the unallowable borrowing after the necessary borrowing has been repaid, an equivalent amount of tainted funded depreciation is cured without regard to the provisions of paragraphs (e)(2)(ii) and (e)(3)(i)(C) of this section.

(3) *Withdrawals of funded depreciation*—(i) *Proper withdrawals.* (A) Withdrawals from funded depreciation are considered proper if made either for the acquisition or replacement of depreciable assets related to the furnishing of patient care or for other capital purposes related to patient care.

(B) *First-in, first-out basis.* Proper withdrawals from funded depreciation are made on a first-in, first-out basis.

(C) *Exception.* If HCFA determines that a borrowing is unnecessary because of the existence of available funded depreciation, and additional deposits have been made to funded depreciation after the occurrence of the unnecessary borrowing, withdrawals made after the date of the additional deposits are deemed to be made on a last-in, first-out basis.

(ii) *Improper withdrawals.* (A) Withdrawals from funded depreciation that do not meet the requirements for proper withdrawals under the provisions in paragraph (e)(3)(i)(A) of this section are considered improper withdrawals.

(B) Improper withdrawals from funded depreciation are made on a last-in, first-out basis. If improper withdrawals are made, interest expense is reduced in accordance with section § 413.153(c)(3).

(C) Improper withdrawals will result in the offset of otherwise allowable interest expense under the offset provisions in § 413.153(c)(3).

(4) *Loans from funded depreciation.* (i) When the general fund of the provider borrows from the funded depreciation to obtain working capital for normal operating expenses to furnish patient care, interest incurred by the general fund is an allowable operating cost only if the interest expense is supported by documents that evidence that the funds were borrowed and that payment of interest and repayment of the funds are required, is separately identified in the provider's accounting records, and meets the necessary and proper tests described in §§413.153(b)(2) and (b)(3). However, if the general fund of the provider borrows from the funded depreciation account to acquire depreciable assets used in furnishing patient care, or for other capital purposes related to patient care, interest expense paid by the general fund to the funded depreciation account is not an allowable cost. Providers are expected to use the funded depreciation for these purposes.

(ii) Loans from funded depreciation to the general fund are considered investments of funded depreciation, but do not have to meet the readily marketable test described in paragraph (e) of this section. Loans made from funded depreciation are subject to the requirement that funded depreciation must be available for the acquisition of depreciable assets used to furnish patient care, or for other capital purposes related to patient care. Costs incurred to secure lines of credit from lending institutions to ensure such availability are not allowable costs.

(iii) Funding of depreciation from general funds will not be recognized to the extent of any outstanding loans from the funded depreciation account to the general fund. Deposits from the general fund into the funded depreciation account must be first applied to reduce any loans outstanding from the funded depreciation to the general fund. When the loans are repaid in full, general funds deposited in the funded depreciation account are considered as repayments of the general fund. Therefore, any subsequent interest expense of the general fund paid to the funded depreciation fund is not an allowable cost.

(iv) A provider may loan its funded depreciation to a related organization for any purpose subject to the following conditions:

(A) Authorization for such a loan by the provider's appropriate managing body of the provider, such as Board of Trustees or Board of Directors, must be on file.

(B) The funded depreciation loaned must remain available, as specified in paragraph (e)(2) of this section, to the provider making the loan. Costs incurred for lines of credit to assure such availability are not allowable costs. During the period of time that the loan is outstanding, if the provider making the loan resorts to outside borrowing for a purpose for which its funded depreciation should have been used, interest expense on an amount of the outside borrowing up to the amount of the funded depreciation that should have been available would be disallowed as unnecessary.

(C) Such loans shall be considered investments of the provider's funded depreciation, but the requirement that funded depreciation be invested in readily marketable investments as required in paragraph (e) of this section is waived for such loans.

(D) The funded depreciation account must earn interest on such loans at a rate that does not exceed the rate that would be charged for a comparable loan from an independent lending institution. This investment income will not be used to reduce the provider's interest expense if all the other conditions in paragraph (e) of this section are met. If the entity borrowing the funds is another provider participating in the Medicare program, the interest expense incurred on such loans would be allowable if the loan meets all of the interest expense requirements specified in §413.153. (For purposes of §413.153(b)(3)(ii), such loans are not considered to be with a related lender.)

(f) *Gains and losses on disposal of assets*—(1) *General.* Depreciable assets may be disposed of through sale, scrapping, trade-in, exchange, demolition, abandonment, condemnation, fire, theft, or other casualty. If disposal of a depreciable asset, including the sale or scrapping of an asset before December

1, 1997, results in a gain or loss, an adjustment is necessary in the provider's allowable cost. (No gain or loss is recognized on either the sale or the scrapping of an asset that occurs on or after December 1, 1997.) The amount of a gain included in the determination of allowable cost is limited to the amount of depreciation previously included in Medicare allowable costs. The amount of a loss to be included is limited to the undepreciated basis of the asset permitted under the program. The treatment of the gain or loss depends upon the manner of disposition of the asset, as specified in paragraphs (f)(2) through (6) of this section. The gain or loss on the disposition of depreciable assets has no retroactive effect on a proprietary provider's equity capital for years prior to the year of disposition.

(2) *Bona fide sale or scrapping before December 1, 1997.* For the bona fide sale or scrapping of depreciable assets before December 1, 1997, the following apply:

(i) Except as specified in paragraph (f)(3) of this section, gains and losses realized from the bona fide sale or scrapping of depreciable assets are included in the determination of allowable cost only if the sale or scrapping occurs while the provider is participating in Medicare. The extent to which such gains and losses are included is calculated by prorating the basis for depreciation of the asset in accordance with the proportion of the asset's useful life for which the provider participated in Medicare. For purposes of this paragraph (f)(2)(i), scrapping refers to the physical removal from the provider's premises of tangible personal properties that are no longer useful for their intended purpose and are only salable for their scrap or junk value.

(ii) If the total amount of gains or losses realized from bona fide sales or scrapping does not exceed $5,000 within the cost reporting period or if the provider's cumulative utilization under the Medicare program is less than 5 percent, the net amount of gains or losses realized from sale or scrapping will be allowed as a depreciation adjustment in the period of disposal. For purposes of this paragraph (f)(2)(ii), the provider's cumulative Medicare utilization precentage is determined by comparing the cumulative total of the Medicare inpatient days for all reporting periods in which depreciation on the asset disposed of was claimed under the Medicare program to the cumulative total of inpatient days of the participating provider for the same reporting periods.

(iii) If the conditions specified in paragraph (f)(2)(ii) of this section are not met, the adjustment to reimbursable cost in the reporting period of asset disposition is calculated as follows:

(A) The total amount of gains or losses shall be allocated to all reporting periods under the Medicare program, based on the ratio of the depreciation allowed on the assets in each reporting period to the total depreciation allowed under the Medicare program.

(B) The results of this allocation are multiplied by the ratio of Medicare reimbursable cost to total allowable cost for each reporting period.

(C) The results of this multiplication are then added.

(D) Effective for cost reporting periods beginning on or after October 1, 1991, no adjustment will be made for the portion of gains or losses allocated to inpatient hospital services for which the hospital was paid under the fully prospective payment methodology as described in § 412.340 of this chapter or under the hold-harmless methodology based on the Federal rate as described in § 412.344(a)(1) of this chapter for new capital costs or in § 412.344(a)(2) of this chapter.

(iv) If a provider sells more than one asset for a lump sum sales price, the gain or loss on the sale of each depreciable asset must be determined by allocating the lump sum sales price among all the assets sold, in accordance with the fair market value of each asset as it was used by the provider at the time of sale. If the buyer and seller cannot agree on an allocation of the sales price, or if they do agree but there is insufficient documentation of the current fair market value of each asset, the intermediary for the selling provider will require an appraisal by an independent appraisal expert to establish the fair market value of each asset

and will make an allocation of the sales price in accordance with the appraisal.

(3) *Sale within 1 year after termination.* Gains and losses realized from a bona fide sale of depreciable assets within 1 year immediately following the date on which the provider terminates participation in the Medicare program are also included in the determination of allowable cost, in accordance with the procedure specified in paragraph (f)(2) of this section. However, if several assets are sold for a lump sum sales price, the determination of fair market value must be based on the appraised value of the assets as they were last used by the provider while participating in the Medicare program.

(4) *Exchange, trade-in or donation.* Gains or losses realized from the exchange, trade-in, or donation of depreciable assets are not included in the determination of allowable cost. When the disposition of an asset is by means of exchange or trade-in, the historical cost of the new asset is the sum of the undepreciated cost of the asset disposed of and the additional cash or other assets transferred (or to be transferred) to acquire the new asset. However, if the asset disposed of was acquired by the provider before its participation in the Medicare program and the sum of the undepreciated cost and the cash or other assets transferred (or to be transferred) exceed the list price or fair market value of the new asset, the historical cost of the new asset is limited to the lower of its list price or fair market value.

(5) *Demolition or abandonment.* (i) For purposes of this section, the term ''abandonment'' means the permanent retirement of an asset for any future purpose, not merely the provider's ceasing to use the asset for patient care purposes. To claim an abandonment under the Medicare program, the provider must have relinquished all rights, title, claim, and possession of the asset with the intention of never reclaiming it or resuming its ownership, possession, or enjoyment.

(ii) If losses resulting from the demolition or abandonment of depreciable assets do not exceed $5,000 within the cost-reporting period, the losses are to be allowed in the period of disposal.

(iii) If losses exceed $5,000 and, at the date of disposition, the demolished or abandoned assets are at least 80 percent depreciated as computed under the straight-line method, such losses are includable in the determination of allowable cost under the Medicare program in the period of disposal and the procedure provided in paragraph (f)(2)(iii) of this section must be used in determining the adjustment to reimbursable cost.

(iv) Losses in excess of $5,000 resulting from the demolition or abandonment of assets, which at the date of disposition are not 80 percent depreciated as computed under the straight-line method, must be capitalized as a deferred charge and amortized as follows:

(A) If the State Health Planning and Development Agency (SHPDA) designated under section 1521 of the Public Health Service Act approves the demolition or abandonment of a depreciable asset as being consistent with the health systems plan of the health service area in which the provider is located, the net loss realized shall be capitalized as a deferred charge and amortized over the remaining life of the demolished or abandoned asset, or at the rate of $5,000 per year, whichever is greater. If no SHPDA exists or if such agency is unable or unwilling to perform this function, the provider must submit a request for approval to the intermediary. The intermediary, after reviewing this request and before issuing the approval, will submit the request along with its recommendation to the appropriate Regional Office for its approval.

(B) If a provider fails to obtain approval as specified in paragraph (f)(5)(iv)(A) of this section, a loss is not allowable unless the demolished or abandoned asset is replaced. If the asset is replaced, the loss resulting from the unapproved demolition or abandonment must be capitalized as a deferred charge and amortized over the estimated useful life of the replacement asset or at the rate of $5,000 per year, whichever is greater.

(v) If a loss resulting from the demolition or abandonment is deferred and amortized and the provider terminates

its participation in the Medicare program or ceases to use a replacement asset in the provision of patient care services, the unamortized deferred charge remaining at that time must not be included in determining allowable cost under the Medicare program.

(vi) Losses on demolition must include the demolition cost incurred by the provider for razing and removal of the asset, less any salvage value recovered by the provider. However, if a provider demolishes a depreciable asset for the purpose of preparing land for future sale, the net demolition cost incurred by the provider (razing and removal costs less salvage recovered) is considered a capital expenditure and added to the historical basis of the land.

(vii) If a provider purchases land on which there is a building, no depreciation will be allowed under the Medicare program unless the building is used in providing patient care. If the building is demolished, the entire purchase price and demolition cost shall be considered the historical cost of the land. If the building is used for patient care, but demolished within 5 years of purchase, the entire purchase price, less allowed depreciation, plus demolition cost will be considered the historical cost of the land.

(6) *Involuntary conversion.* (i) Losses resulting from the involuntary conversion of depreciable assets, such as condemnation, fire, theft, or other casualty, are generally included in the determination of allowable cost on a deferred basis if the asset is restored or replaced. However, losses resulting from a provider's imprudent management of its depreciable assets, such as the failure to obtain proper insurance coverage, are not included in the determination of allowable cost.

(ii) The net allowable loss from involuntary conversion must consist of the undepreciated cost of unrecovered book value of the asset, less amounts received from insurance proceeds gifts, and grants received from local, State, or Federal government, or any other source as a result of the involuntary conversion.

(iii) If the asset is replaced and the net allowable loss in any cost-reporting period does not exceed $5,000, the entire amount must be included in allowable cost in the period in which the loss is incurred. If the asset is replaced and the net allowable loss in any cost-reporting period exceeds $5,000, the loss must be capitalized as a deferred charge and amortized over the useful life of the replacement or restored asset. If a replaced or restored asset ceases to be used in the provision of patient care services or the provider terminates its participation in the Medicare program, the unamortized deferred charge remaining at that time will not be included in determining allowable cost under the Medicare program.

(iv) If the provider fails to replace or restore an involuntarily converted asset, the loss is not included in determining allowable cost. However, if the provider intends to replace or restore the asset but is unable to do so because the designated SHPDA finds such replacement or restoration to be inconsistent with the health systems plan of the provider's health service area, the loss is allowable so long as the provider continues to participate in Medicare. In this case, the loss must be capitalized as a deferred charge and amortized over the remaining life of the involuntarily converted asset, or at the rate of $5,000 per year, whichever is greater.

(v) If a gain is realized from an involuntary conversion of depreciable assets, the net amount realized reduces the basis of the restored or replacement asset. If the asset is not restored or replaced, the gain is to be treated in accordance with paragraph (f)(2) of this section.

(7) *Effect on equity capital.* The unrecovered loss entered on the books of the provider as a deferred charge, in accordance with paragraphs (f) (5) and (6) of this section, is not includable in the computation of equity capital under § 413.157.

(8) *Sale of replacement or restored assets.* If a provider sells a replacement or restored asset while participating in the Medicare program or within 1 year immediately following the date on which it terminates its participation in the Medicare program, the unrecovered loss entered on the books of the provider as a deferred charge in accordance with paragraphs (f) (5) and (6) of

this section will not be included in determining the gain or loss realized from the sale of the replacement or restored asset. However, if the sale of such asset is made to a related organization, as defined in §413.17, and the purchasing organization continues as a provider in the Medicare program, the remaining deferred charge representing the unrecovered depreciable basis of the demolished, abandoned or destroyed asset must continue to be amortized over the remaining expected useful life of the replacement or restored asset. If the sale is made to an unrelated organization, further amortization of the deferred charge is not allowed.

(g) *Establishment of cost basis on purchase of facility as an ongoing operation*—(1) *Assets acquired after July 1, 1966 and before August 1, 1970.* The cost basis for the assets of a facility purchased as an ongoing operation after July 1, 1966, and before August 1, 1970, is the lowest of the—

(i) Total price paid for the facility by the purchaser, as allocated to the individual assets of the facility;

(ii) Total fair market value of the facility at the time of the sale, as allocated to the individual assets; or

(iii) Combined fair market value of the individually identified assets at the time of the sale.

(2) *Assets acquired after July 31, 1970 and, for hospitals and SNFs, before July 18, 1984.* For depreciable assets acquired after July 31, 1970 and, for hospitals and SNFs, before July 18, 1984, in addition to the limitations specified in paragraph (g)(1) of this section, the cost basis of the depreciable assets may not exceed the current reproduction cost depreciated on a straight-line basis over the life of the asset to the time of the sale.

(3) *Assets acquired by hospitals and SNFs on or after July 18, 1984 and not subject to an enforceable agreement entered into before that date.* Subject to paragraphs (b)(1)(ii) (B) through (G) and (b)(1)(iii) of this section, historical cost may not exceed the lowest of the following:

(i) The allowable acquisition cost of the asset to the owner of record as of July 18, 1984 (or, in the case of an asset not in existence as of July 18, 1984, the first owner of record of the asset);

(ii) The acquisition cost to the new owner; or

(iii) The fair market value of the asset on the date of acquisition.

(4) *Assets acquired by all providers on or after December 1, 1997.* Subject to the provisions of paragraph (b)(1)(i)(A) of this section, the historical cost may not exceed the historical cost of the asset, as recognized under the Medicare program, less depreciation allowed, to the owner of record as of August 5, 1997 (or for an asset not in existence as of August 5, 1997, the first owner of record after August 5, 1997).

(5) *Transactions other than bona fide.* If the purchaser cannot demonstrate that the sale was bona fide, in addition to the limitations specified in paragraph (g)(1), (2), and (3) of this section, the purchaser's cost basis may not exceed the seller's cost basis, less accumulated depreciation.

(h) *Sale and leaseback agreements and other lease transactions.* (1) For sale and leaseback agreements for all providers, and for sale and leaseback agreements for hospitals and SNFs entered into before October 23, 1992, a provider may include in its allowable costs incurred rental charges, as specified in a sale and leaseback agreement with a nonrelated purchaser involving plant facilities or equipment, only if—

(i) The rental charges are reasonable based on consideration of rental charges of comparable facilities and market conditions in the area; the type, expected life, condition, and value of the facilities or equipment rented; and other provisions of the rental agreement;

(ii) Adequate alternate facilities or equipment that would serve the purpose are not or were not available at lower cost; and

(iii) The leasing was based on economic and technical considerations.

(2) If the conditions of paragraph (h)(1) of this section are not met, the amount a provider may include in its allowable costs as rental or lease expense under a sale and leaseback agreement may not exceed the amount that the provider would have included in its allowable costs had the provider retained legal title to the facilities or

equipment such as interest expense on mortgages, taxes, depreciation, and insurance costs.

(3) For hospitals and SNFs entering into sale and leaseback agreements on or after October 23, 1992, the amount a provider may include in its allowable costs as rental or lease expense may not exceed the amount that the provider would have included in its allowable costs had the provider retained legal title to the facilities or equipment, such as interest expense on mortgages, taxes, depreciation, and insurance costs (the costs of ownership). This limitation applies both on an annual basis and over the useful life of the asset.

(i) If in the early years of the lease, the annual rental or lease costs are less than the annual costs of ownership, but in the later years of the lease the annual rental or lease costs are more than the annual costs of ownership, in the years that the annual rental or lease costs are more than the costs of ownership the provider may include in allowable costs annually the actual amount of rental or lease costs. The aggregate rental or lease costs included in allowable costs may not exceed the aggregate costs of ownership that would have been included in allowable costs over the useful life of the asset had the provider retained legal title to the asset.

(ii) If in the early years of the lease, the annual rental or lease costs exceed the annual costs of ownership, but in the later years of the lease the annual rental or lease costs are less than the annual costs of ownership, the provider may carry forward amounts of rental or lease costs that were not included in allowable costs in the early years of the lease due to the costs of ownership limitation, and include these amounts in allowable costs in the years of the lease when the annual rental or lease costs are less than the annual costs of ownership. In any given year the amount of actual annual rental or lease costs plus the amount carried forward to that year may not exceed the amount of the costs of ownership for that year.

(iii) In the aggregate, the amount of rental or lease costs included in allowable costs may not exceed the amount of the costs of ownership that the provider could have included in allowable costs had the provider retained legal title to the asset.

(4) For lease transactions of all providers entered into before October 23, 1992, a lease that meets the following conditions establishes a virtual purchase:

(i) The rental charge exceeds rental charges of comparable facilities or equipment in the area.

(ii) The term of the lease is less than the useful life of the facilities or equipment.

(iii) The provider has the option to renew the lease at a significantly reduced rental, or the provider has the right to purchase the facilities or equipment at a price that appears to be significantly less than what the fair market value of the facilities or equipment would be at the time acquisition by the provider is permitted.

(5)(i) If a lease is a virtual purchase under paragraph (h)(4) of this section, the rental charge is includable in allowable costs only to the extent that it does not exceed the amount that the provider would have included in allowable costs if it had legal title to the asset (the cost of ownership), such as straight-line depreciation, insurance, and interest. For purposes of computing the limitation on allowable rental cost in this paragraph, a provider may not include accelerated depreciation.

(ii) The difference between the amount of rent paid and the amount of rent allowed as rental expense is considered a deferred charge and must be capitalized as part of the historical cost of the asset when the asset is purchased.

(iii) If an asset is returned to the owner instead of being purchased, the deferred charge may be expensed in the year the asset is returned.

(iv) If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase still exists, the deferred charge may be expensed to the extent of increasing the reduced rental to an amount not in excess of the cost of ownership.

(v) If the term of the lease is extended for an additional period of time

at a reduced lease cost and the option to purchase no longer exists, the deferred charge may be expensed to the extent of increasing the reduced rental to a fair rental value.

(6) For lease transactions entered into on or after October 23, 1992, a lease that meets any one of the following conditions establishes a virtual purchase:

(i) The lease transfers title of the facilities or equipment to the lessee during the lease term.

(ii) The lease contains a bargain purchase option.

(iii) The lease term is 75 percent or more of the useful life of the facilities or equipment. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment.

(iv) The present value of the minimum lease payments (that is, payments to be made during the lease term, including bargain purchase option, guaranteed residual value, or penalties for failure to renew) equals 90 percent or more of the fair market value of the leased property. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment. The present value is computed using the lessee's incremental borrowing rate, unless the interest rate implicit in the lease is known and is less than the lessee's incremental borrowing rate, in which case, the interest rate implicit in the lease is used.

(7)(i) If a lease is a virtual purchase under paragraph (h)(6) of this section, the rental charge is includable in allowable costs only to the extent that it does not exceed the amount that the provider would have included in allowable costs if it had legal title to the asset (the costs of ownership), such as straight-line depreciation, insurance, and interest. For purposes of computing the limitation on allowable rental cost as described in this paragraph, a provider may not include accelerated depreciation in its allowable costs.

(ii) The difference between the amount of rent paid and the amount of rent allowed as rental expense is considered a deferred charge and is capitalized as part of the historical cost of the asset when the asset is purchased.

(iii) If an asset is returned to the owner instead of being purchased, the deferred charge may be expensed in the year the asset is returned.

(iv) If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase still exists, the deferred charge may be expensed to the extent of increasing the reduced rental to an amount not in excess of the cost of ownership.

(v) If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase no longer exists, the deferred charge may be expensed to the extent of increasing the reduced rental to a fair rental value.

(vi) If the lessee becomes the owner of the leased asset (either by operation of the lease or by other means), the amount considered as depreciation, for the purpose of having computed the limitation expressed in paragraph (h)(7)(i) of this section, must be used in calculating the limitation on adjustments to depreciation for the purpose of determining any gain or loss upon disposal of an asset under paragraph (f) of this section.

(i) *Intergovernmental transfer of facilities.* The basis for depreciation of assets transferred under appropriate legal authority from one governmental entity to another is as follows:

(1) The historical cost incurred by the present owner in acquiring the asset under a bona fide sale. The historical cost may not exceed the lower of current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of the purchase of fair market value at the time of the purchase.

(2) The fair market value at the time of donation under a bona fide donation of the asset (subject to the limitations set forth under paragraph (i) of this section). An asset is considered donated when a governmental entity acquires the asset without assuming the functions for which the transferor used the asset or making any payment for it in the form of cash, property, or services.

(3) If neither paragraph (h) (1) nor (2) of this section applies, for example, the transfer was solely to facilitate administration or to reallocate jurisdictional responsibility, or the transfer constituted a taking over in whole or in part of the function of one governmental entity by another governmental entity, the basis for depreciation is—

(i) With respect to an asset on which the transferor has claimed depreciation under the Medicare program, the transferor's basis under the Medicare program prior to the transfer. The method of depreciation used by the transferee may be the same as that used by the transferor, or the transferee may change the method, as permitted under paragraph (d)(2) of this section; or

(ii) With respect to an asset on which the transferor has not claimed depreciation under the Medicare program, the cost incurred by the transferor in acquiring the asset (not to exceed the basis that would have been recognized had the transferor participated in the Medicare program) less depreciation calculated on the straight-line basis over the life of the asset to the time of transfer.

(j) *Basis of assets donated to a provider*—(1) Assets not used or depreciated under the Medicare program. If an asset has never been used or depreciated under the Medicare program and is donated to a provider, the basis for the purpose of calculating depreciation and equity capital (if applicable) is the fair market value of the asset at the time of donation.

(2) *Assets used or depreciated under the Medicare program.* If an asset has been used or depreciated under the Medicare program and is donated to a provider, the basis for the purpose of calculating depreciation and equity capital (if applicable) is the lesser of—

(i) The fair market value at the time of donation; or

(ii) The net book value in the hands of the owner last participating in the Medicare program.

(3) *Transfers of State hospitals to nonprofit corporations without monetary consideration.* If a State transfers a hospital to a nonprofit corporation without monetary consideration on or after July 18, 1984, the depreciable basis of the assets to the new owner is the net book value of the assets as recorded on the State's books at the time of the transfer. For purposes of this section, monetary consideration includes cash, new debt, and assumed debt.

(k) *Limitation on Federal participation for capital expenditures.* The allowance for depreciation is not an allowable cost for certain capital expenditures as described in § 413.161.

(l) *Transactions involving a provider's capital stock*—(1) *Acquisition of capital stock of a provider.* If the capital stock of a provider is acquired, the provider's assets may not be revalued. For example, if Corporation A purchases the capital stock of Corporation B, the provider, Corporation B continues to be the provider after the purchase and Corporation A is merely the stockholder. Corporation B's assets may not be revalued.

(2) *Statutory merger.* A statutory merger is a combination of two or more corporations under the corporation laws of the State, with one of the corporations surviving. The surviving corporation acquires the assets and liabilities of the merged corporation(s) by operation of State law. The effect of a statutory merger upon Medicare reimbursement is as follows:

(i) *Statutory merger between unrelated parties.* If the statutory merger is between two or more corporations that are unrelated (as specified in § 413.17), the assets of the merged corporation(s) acquired by the surviving corporation may be revalued in accordance with paragraph (g) of this section. If the merged corporation was a provider before the merger, then it is subject to the provisions of paragraphs (d)(3) and (f) of this section concerning recovery of accelerated depreciation and the realization of gains and losses. The basis of the assets owned by the surviving corporation are unaffected by the transaction. An example of this type of transaction is one in which Corporation A, a nonprovider, and Corporation B, the provider, are combined by a statutory merger, with Corporation A being the surviving corporation. In such a case the assets of Corporation B acquired by Corporation A may be revalued in accordance with paragraph (g) of this section.

(ii) *Statutory merger between related parties.* If the statutory merger is between two or more related corporations (as specified in §413.17), no revaluation of assets is permitted for those assets acquired by the surviving corporation. An example of this type of transaction is one in which Corporation A purchase the capital stock of Corporation B, the provider. Immediately after the acquisition of the capital stock of Corporation B, there is a statutory merger of Corporation B and Corporation A, with Corporation A being the surviving corporation. Under these circumstances, at the time of the merger the transaction is one between related parties and is not a basis for revaluation of the provider's assets.

(3) *Consolidation.* A consolidation is the combination of two or more corporations resulting in the creation of a new corporate entity. If at least one of the original corporations is a provider, the effect of a consolidation upon Medicare reimbursement for the provider is as follows:

(i) *Consolidation between unrelated parties.* If the consolidation is between two or more corporations that are unrelated (as specified in §413.17), the assets of the provider corporation(s) may be revalued in accordance with paragraph (g) of this section.

(ii) *Consolidation between related parties.* If the consolidation is between two or more related corporations (as specified in §413.17), no revaluation of provider assets is permitted.

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§413.139 Depreciation: Optional allowance for depreciation based on a percentage of operating costs.

(a) *Principle.* With respect to all assets acquired before 1966, the provider, at its option, may choose an allowance for depreciation based on a percentage of operating costs. The operating costs to be used are the provider's 1965 operating costs or the provider's current year's allowable costs, whichever are the lower. The percentage to be applied is 5 percent starting with the year 1966–67, with such percentage being uniformly reduced by one-half percent each succeeding year. The allowance based on operating costs is in addition to regular depreciation on assets acquired after 1965; however, if the optional allowance is selected, the combined amount of such allowance on pre-1966 assets and the straight-line depreciation on assets acquired after 1965 (including the estimated depreciation on assets held on a rental basis during the current year) may not exceed 6 percent of the provider's allowable cost for the current year.

(b) *Definitions*—(1) *Operating costs.* Operating costs are the total costs incurred by the provider in operating the institution or facility.

(2) *Allowable costs.* Allowable costs are the costs of a provider that are includable under the principles for cost reimbursement. Through application of apportionment methods to the total amount of such allowable costs, the share of a provider's total cost that is attributable to covered services for beneficiaries is determined.

(c) *Application.* If a provider has inadequate historical cost records for pre-1966 depreciable assets, the provider may elect to receive an allowance for depreciation on such assets based on a percentage of operating costs. The optional allowance for depreciation for such assets may be used, however, whether or not a provider has records of the cost of pre-1966 depreciable assets currently in use.

(d) *Allowance based on a percentage of operating costs.* (1) The allowance for depreciation based on a percentage of operating costs is to be computed by applying a specified percentage to a base amount equal to the provider's 1965 total operating costs, without adjustments to these principles or the current year's allowable operating costs, whichever is lower. The percentage to be applied is five for the reporting period that starts before or during 1966–67, four and one-half for the reporting period that begins during 1967–68, and continues to decline annually by equal amounts to become zero in 1976–77.

(2) If used as a base for determining the optional allowance for depreciation, neither the 1965 operating costs nor the current year's allowable costs

are to include any actual depreciation, estimated depreciation on rented depreciable-type assets, allowance in lieu of specific recognition of other costs, or return on equity capital. Such exclusions are to be made only for the purpose of computing the allowance for depreciation based on operating costs. For other purposes, the excluded amounts are recognized in determining allowable costs and for computing the costs of services furnished to Medicare beneficiaries during the reporting period.

(e) *Change to actual depreciation.* (1) A provider that elects this allowance may at any time before 1976 change to actual depreciation on all pre-1966 depreciable assets. In such case, this option is eliminated and the provider can no longer elect to receive an allowance for depreciation based on a percentage of operating costs.

(2) If the provider desires to change to actual depreciation but either has no historical cost records or has incomplete records, the determination of historical cost may be made through appropriate means involving expert consultation with the determination being subject to review and approval by the intermediary.

(f) *Determination of optional allowance based on percentage of operating costs illustrated.* The following illustrates how the provider would determine the optional allowance for depreciation based on operating costs.

Example No. 1. The provider keeps its records on a calendar year basis. The current year's actual allowable cost and the actual operating cost for 1965 do not include any actual depreciation or rentals on depreciable-type assets. The current year's allowable cost also does not include any allowance in lieu of specific recognition of other costs or return on equity capital.

YEAR 1966

Current year's allowable cost	$1,100,000
Operating cost for 1965[1]	$1,000,000
Percent for determining the allowance	5
Allowance	$50,000

[1] 1965 Operating cost was used in computing the allowance for depreciation based on a percentage of operating costs because it was lower than 1966 allowable cost.

YEAR 1967

Current year's allowable cost	$1,200,000
Operating cost for 1965[1]	$1,000,000
Percent for determining the allowance[2]	5
Allowance	$50,000

[1] 1965 Operating cost was used in computing the allowance for depreciation based on a percentage of operating costs because it was lower than 1967 allowable cost.
[2] Since the reporting period began during the year 1966–1967 (July 1, 1966–June 30, 1967) 5 percent is the percentage to be used.

YEAR 1968

Operating cost for 1965	$1,000,000
Current year's allowable cost[1]	$900,000
Percent for determining the allowance[2]	4½
Allowance	$40,500

[1] The current year's allowable cost was used in computing the allowance for depreciation based on percentage of operating costs because it was lower than 1965 operating cost.
[2] Since the reporting period began during the year 1967–1968 (July 1, 1967–June 30, 1968) 4½ percent is the percentage to be used.

Example No. 2. When the provider pays rent for depreciable-type assets rented prior to 1966, the estimated depreciation on such assets must be deducted from the allowance. The following illustration demonstrates how the allowance is determined.

The provider keeps its records on a calendar year basis. The current year's actual allowable cost and the actual operating cost for 1965 did not include any actual depreciation, allowance in lieu of specific recognition of other costs, or return on equity capital. However, such costs have been adjusted to exclude estimated depreciation on rented depreciable-type assets.

YEAR 1966

Adjusted current year's allowable cost	$1,100,000
Adjusted operating cost for 1965[1]	$1,000,000
Percent for determining the allowance	5
Allowance	$50,000
Less estimated depreciation for depreciable-type assets rented prior to 1966 on which rental is paid in 1966	$3,000
Adjusted allowance	$47,000

[1] 1965 operating cost was used in computing the allowance for depreciation based on a percentage of operating costs because it was lower than 1966 allowable cost.

(g) *Limitation on depreciation if optional allowance is used.* This optional allowance only is subject to a limitation based on the provider's total allowable operating cost for the current year. To determine this limitation, compute the sum of the actual depreciation claimed, the allowance based on a percentage of operating costs, and the estimated straight-line depreciation on depreciable-type assets rented after 1965. If this sum exceeds six percent of the provider's current year's allowable cost (exclusive of any actual

depreciation claimed, estimated depreciation on rented depreciable-type assets, allowance in lieu of specific recognition of other costs, and return on equity capital), the allowance for depreciation based on a percentage of operating costs is reduced by the amount of excess. In applying this limitation, if the actual depreciation claimed is on an accelerated basis, it must be converted to a straight-line basis only for use in calculating this limitation. It is presumed that pre-1966 assets will not be retired at a greater than normal rate, and the limitation of six percent, as it affects the availability of the allowance, is designed as a safeguard if the presumption is not borne out. If the provider does not elect to use the optional allowance, the combined allowance for depreciation based on costs of pre-1966 assets and those subsequently acquired is not subject to the six percent limitation.

Example No. 1. The following illustration demonstrates how this limitation would be determined.

YEAR 1966

[The provider keeps its records on a calendar year basis. The current year's actual allowable cost and the actual operating cost for 1965 have been adjusted to exclude actual depreciation, the estimated depreciation on rented depreciable-type assets, allowance in lieu of specific recognition of other costs, and return on equity capital.]

Adjusted operating cost for 1965	$1,000,000
Percent for determining the allowance	5
In 1966 assets were acquired which produce a straight-line depreciation of	$18,000
Estimated depreciation on assets rented in 1966	$2,000
Adjusted allowable operating cost for 1966	$1,100,000

CALCULATION OF ALLOWANCE FOR DEPRECIATION BASED ON A PERCENTAGE OF OPERATING COSTS

Gross allowance	
5 percent times adjusted 1965 operating costs ($1,000,000)	$50,000
Estimated depreciation on assets rented in 1966	2,000
Straight-line depreciation on post-1965 assets	18,000
Total	70,000
6 percent of adjusted 1966 allowable operating cost	66,000
Reduction in allowance	4,000
Allowance	50,000
Reduction	4,000
Adjusted allowance	46,000
Total depreciation allowance for 1966 ($18,000 actual depreciation plus $46,000 allowance based on operating cost)	64,000

Assume in this illustration that the provider had elected to use the declining balance method in computing its allowable depreciation and the rental expense for depreciable-type assets was $3,500. In that case, it would include in its 1966 allowable cost not only the $46,000 allowance based on operating costs but also $36,000 (in this instance 2×straight-line rate is used) in actual depreciation and the rental expense of $3,500—or a total of $85,500 covering all its depreciable assets.

§ 413.144 Depreciation: Allowance for depreciation on fully depreciated or partially depreciated assets.

(a) *Principle.* Depreciation on assets being used by a provider at the time it enters into the Medicare program is allowed. This principle applies even though such assets may be fully or partially depreciated on the provider's books.

(b) *Application.* Depreciation is allowable on assets being used at the time the provider enters into the program. This applies even though such assets may be fully depreciated on the provider's books or fully depreciated with respect to other third-party payers. So long as an asset is being used, its useful life is considered not to have ended, and consequently the asset is subject to depreciation based upon a revised estimate of the asset's useful life as determined by the provider and approved by the intermediary. Correction of prior years' depreciation to reflect revision of estimated useful life should be made in the first year of participation in the program unless the provider has used the optional method (§ 413.139), in which case the correction should be made at the time of discontinuing the use of that method. If an asset has become fully depreciated under Medicare, further depreciation is not appropriate or allowable, even though the asset may continue in use.

(c) *Example of an allowance for a fully-depreciated asset.* For example, if a 50-year-old building is in use at the time the provider enters into the program, depreciation is allowable on the building even though it has been fully depreciated on the provider's books. Assuming that a reasonable estimate of the asset's continued life is 20 years (70 years from the date of acquisition), the provider may claim depreciation over

the next 20 years—if the asset is in use that long—or a total depreciation of as much as twenty-seventieths of the asset's historical cost.

(d) *Corrections to depreciation.* If the asset is disposed of before the expiration of its estimated useful life, the depreciation would be adjusted to the actual useful life. Likewise, a provider may not have fully depreciated other assets it is using and finds that it has incorrectly estimated the useful lives of those assets. In such cases, the provider may use the corrected useful lives in determining the amount of depreciation, provided such corrections have been approved by the intermediary.

§ 413.149 Depreciation: Allowance for depreciation on assets financed with Federal or public funds.

(a) *Principle.* Depreciation is allowed on assets financed with Hill-Burton or other Federal or public funds.

(b) *Application.* Like other assets (including other donated depreciable assets), assets financed with Hill-Burton or other Federal or public funds become a part of the provider institution's plant and equipment to be used in furnishing services. It is the function of payment of depreciation to provide funds that make it possible to maintain the assets and preserve the capital employed in the production of services. Therefore, irrespective of the source of financing of an asset, if it is used in the providing of services for beneficiaries of the program, payment for depreciation of the asset is, in fact, a cost of the production of those services. Moreover, recognition of this cost is necessary to maintain productive capacity for the future. An incentive for funding of depreciation is provided in these principles by the provision that investment income on funded depreciation is not treated as a reduction of allowable interest expense under § 413.153(a).

§ 413.153 Interest expense.

(a)(1) *Principle.* Necessary and proper interest on both current and capital indebtedness is an allowable cost. However, interest costs are not allowable if incurred as a result of—

(i) Judicial review by a Federal court (as described in § 413.64(j));

(ii) An interest assessment on a determined overpayment (as described in § 405.377 of this chapter); or

(iii) Interest on funds borrowed to repay an overpayment (as described in § 413.64(j) or § 405.378 of this chapter), up to the amount of the overpayment, unless the provider had made a prior commitment to borrow funds for other purposes (for example, capital improvements).

(2) *Exception.* In those cases of administrative or judicial reversal, interest paid on funds borrowed to repay an overpayment is an allowable cost, in accordance with this section.

(b) *Definitions*—(1) *Interest.* Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. This is usually for such purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as acquisition of facilities and equipment, and capital improvements. Generally, loans for capital purposes are long-term loans.

(2) *Necessary.* Necessary interest is interest that meets the following requirements:

(i) It is incurred on a loan made to satisfy a financial need of the provider. Loans that result in excess funds or investments are not considered necessary.

(ii) It is incurred on a loan made for a purpose reasonably related to patient care.

(iii) It is reduced by investment income except income from—

(A) Gifts, grants, and endowments, whether held separately or pooled with other funds;

(B) Funded depreciation that meets the program's qualifying criteria;

(C) The provider's qualified pension funds;

(D) The provider's deferred compensation funds that meet the program's qualifying criteria; and

(E) The provider's self-insurance trust funds that meet the program's qualifying criteria.

(iv) It is not reduced by interest received as a result of judicial review by a Federal court (as described in §413.64(j)).

(3) *Proper.* Proper requires that interest be—

(i) Incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made; and

(ii) Paid to a lender not related through control or ownership, or personal relationship to the borrowing organization. However, interest is allowable if paid on loans from the provider's donor-restricted funds, the funded depreciation account, or the provider's qualified pension fund.

(4) *Zero coupon bonds.* Zero coupon bonds are issued by government agencies, corporations, and banks at a price substantially below the face value. The difference between the purchase price and the face value reflects the actual amount of interest and is neither a discount nor an adjustment to the interest rate as with other bonds. Interest is paid at maturity when the bond is redeemed at face value.

(c) *Borrower-lender relationship.* (1) Except as described in paragraph (c)(2) of this section, to be allowable, interest expense must be incurred on indebtedness established with lenders or lending organizations not related through control, ownership, or personal relationship to the borrower. Presence of any of these factors could affect the ''bargaining'' process that usually accompanies the making of a loan, and could thus be suggestive of an agreement on higher rates of interest or of unnecessary loans. Loans should be made under terms and conditions that a prudent borrower would make in armslength transactions with lending institutions. The intent of this provision is to assure that loans are legitimate and needed, and that the interest rate is reasonable. Thus, interest paid by the provider to partners, stockholders, or related organizations of the provider would not be allowable. If the owner uses his own funds in a business, it is reasonable to treat the funds as invested funds or capital, rather than borrowed funds. Therefore, if interest on loans by partners, stockholders, or related organizations is disallowed as a cost solely because of the relationship factor, the principal of such loans is treated as invested funds in the computation of the provider's equity capital under §413.157.

(2) Exceptions to the general rule regarding interest on loans from controlled sources of funds are made in the following circumstances. Interest on loans to providers by partners, stockholders, or related organizations made prior to July 1, 1966, is allowable as cost, provided that the terms and conditions of payment of such loans have been maintained in effect without modification subsequent to July 1, 1966. If the general fund of a provider ''borrows'' from a donor-restricted fund and pays interest to the restricted fund, this interest expense is an allowable cost. The same treatment is accorded interest paid by the general fund on money ''borrowed'' from the funded depreciation account of the provider or from the provider's qualified pension fund. In addition, if a provider operated by members of a religious order borrows from the order, interest paid to the order is an allowable cost.

(3) If funded depreciation is used for purposes other than improvement, replacement, or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment is accorded deposits in the provider's qualified pension fund if such deposits are used for other than the purpose for which the fund was established.

(d) *Loans not reasonably related to patient care.* (1) The following types of loans are not considered to be for a purpose reasonably related to patient care:

(i) For loans made to finance acquisition of a facility, that portion of the cost that exceeds—

(A) Historical cost as determined under §413.134(b); or

(B) The cost basis determined under §413.134(g); and

(ii) Loans made to finance capital stock acquisitions, mergers, or consolidations for which revaluation of assets is not allowed under §413.134(k).

(2) In determining whether a loan was made for the purpose of acquiring

a facility, we apply any owner's investment or funds first to the tangible assets, then to the intangible assets other than goodwill, and lastly to the goodwill. If the owner's investment or funds are not sufficient to cover the cost allowed for tangible assets, we apply funds borrowed to finance the acquisition to the portion of the allowed cost of the tangible assets not covered by the owner's investment, then to the intangible assets other than goodwill, and lastly to the goodwill. Repayments of the funds borrowed are applied first to the borrowing related to the tangible assets, then to the borrowing related to the intangible assets other than goodwill, and lastly to the borrowing related to the goodwill.

(3) When a provider borrows funds, but only some of the funds are necessary, repayments of the loan (principal and interest portions) are applied first to pay for the necessary portion of the loan. Only after all of the necessary portion of the loan (principal and interest) has been repaid are any repayments applied to the unnecessary portion of the loan. Repayments toward non-allowable borrowing pertaining to assets or activities not related to patient care are considered investments, and the provisions of paragraph (b)(2)(iii) of this section are applied.

(e) *Limitation on Federal participation for capital expenditures.* The allowance for depreciation is not an allowable cost for certain capital expenditures as described in § 413.161.

(f) *Zero coupon bonds*—(1) *Interest on bonds issued on or after August 15, 1996.* For zero coupon bonds issued on or after August 15, 1996, interest expense incurred to provide funds for patient care-related costs is an allowable expense, and interest income earned for investment purposes is an allowable offset, in the cost reporting period in which the interest accrues.

(2) *Interest income offset.* Interest income from zero coupon bonds must be offset against allowable interest expense as prescribed in paragraph (b)(2) of this section and in § 413.130(g)(2). If zero coupon bonds are purchased with the proceeds of an advanced refunding of debt, offset of the investment income is required under § 413.153(b)(2)(iii), but the investment income is not prorated under § 413.130(g)(2).

(3) *Use of effective interest method.* (i) Interest expense and interest income from zero coupon bonds that are reported as they accrue must be amortized using the effective interest method. This method recognizes the actual accrual of interest expense or income for each interest computation period (as specified by the bond instrument) throughout the life of the bond.

(ii) A constant effective yield rate is determined and applied to the book value (outstanding loan balance including prior accrued interest) of the bond at the beginning of each period to determine the total interest for the period.

(iii) If the interest computation period involves portions of more than one cost reporting period, the amount of interest for that computation period shall be apportioned to each cost reporting period.

(iv) An example of the computation of interest using the effective interest method follows:

Facts

Life of zero coupon bond: 15 years.

Value at maturity: $50,000.

Bondholder pays $6,996 for the bond.

Annual interest rate is 13.5506% compounded semi-annually.

From the table below, interest for the first year would be $980.11 ($474.00 plus $506.11).

Col 1 Six-month periods	Col 2 Book value beginning of period	Col. 3 Effective interest*	Col. 4 Book value end of period (columns 2 + 3)
1	$6,996.00	$474.00	$7,470.00
2	7,470.00	506.11	7,976.11
3	7,976.11	540.40	8,516.51
4	8,516.51	577.02	9,093.53
29	43,855.94	2,971.37	46,827.31
30	46,827.31	3,172.69	50,000.00

*Computed by multiplying the book value at the beginning of each period (Column 2) by 6.7753% (the annual interest rate of 13.5506% 2 = 6.7753%).

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§ 413.157 Return on equity capital of proprietary providers.

(a) *Definitions.* For purposes of this section—

Proprietary provider means a provider that is organized and operated with the expectation of earning a profit for its owners (as distinguished from a provider that is organized and operated on a nonprofit basis). Proprietary providers may be sole proprietorships, partnerships, or corporations. Effective for cost reporting periods beginning on or after July 6, 1987, the term applies only to proprietary hospitals and SNFs.

(b) *General rule.* A reasonable return on equity capital invested and used in the provision of patient care is paid as an allowance in addition to the reasonable cost of covered services furnished to beneficiaries by proprietary providers.

(1) *Rate of return applicable to proprietary providers for cost reporting periods beginning before July 6, 1987.* Except as provided in paragraphs (b)(2), (b)(3), and (b)(4) of this section, the amount allowable on an annual basis, for cost reporting periods beginning before July 6, 1987, is determined by multiplying the provider's equity capital by a percentage equal to one and one-half times the average of the rates of interest on special issues of public debt obligations issued for purchase by the Medicare Part A Trust Fund for each of the months during the provider's reporting period or portion thereof covered under the program.

(2) *Rate of return for inpatient hospital services furnished by proprietary hospitals.* The rate used in determining the return for inpatient hospital services is a percentage of the average of the rates of interest described in paragraph (b)(1) of this section. The percentages applicable to inpatient hospital services are as follows:

(i) 150 percent for cost reporting periods beginning before April 20, 1983.

(ii) 100 percent for cost reporting periods beginning on or after April 20, 1983 and before October 1, 1986.

(iii) 75 percent for cost reporting periods beginning on or after October 1, 1986 and before October 1, 1987.

(iv) 50 percent for cost reporting periods beginning on or after October 1, 1987 and before October 1, 1988.

(v) 25 percent for cost reporting periods beginning on or after October 1, 1988 and before October 1, 1989.

(vi) Zero percent for cost reporting periods beginning on or after October 1, 1989.

(3) *Rate of return related to proprietary SNFs.* (i) For cost reporting periods beginning on or after October 1, 1985, the rate used in determining the return for SNF services furnished before October 1, 1993, is a percentage equal to the average of the rates of interest described in paragraph (b)(1) of this section.

(ii) There is no allowance for return for SNF services furnished on or after October 1, 1993.

(4) *Rate of return related to outpatient hospital services.* (i) For cost reporting periods beginning on or after October 1, 1985, the rate used in determining the return for outpatient hospital services furnished before January 1, 1988 is a percentage equal to the average of the rates of interest described in paragraph (b)(1) of this section.

(ii) There is no allowance for return for outpatient hospital services furnished on or after January 1, 1988.

(5) *Rate of return for proprietary services of all nonhospital and non-SNF providers.* (i) For cost reporting periods beginning on or after October 1, 1985, but before July 6, 1987, the rate used in determining the return for services of all nonhospital and non-SNF providers is a percentage equal to the average of the rates of interest described in paragraph (b)(1) of this section.

(ii) For cost reporting periods beginning on or after July 6, 1987, there is no allowance for return on equity capital for nonhospital and non-SNF providers.

(c) *Application*—(1) *Computation of equity capital.* For purposes of computing the allowable return, the provider's equity capital means—

(i) The provider's investment in plant, property, and equipment related to patient care (net of depreciation) and funds deposited by a provider who leases plant, property, or equipment related to patient care and is required by the terms of the lease to deposit such funds (net of noncurrent debt related

to such investment or deposited funds); and

(ii) Net working capital maintained for necessary and proper operation of patient care activities. However, debt representing loans from partners, stockholders, or related organizations on which interest payments would be allowable as costs but for the provisions of §413.153(b)(3)(ii), is not subtracted in computing the amount of equity capital in order that the proceeds from such loans be treated as part of the provider's equity capital. In computing the amount of equity capital upon which a return is allowable, investment in facilities is recognized on the basis of the historical cost, or other basis, used for depreciation and other purposes under Part A of Medicare.

(2) *Acquisitions after July 1970.* With respect to a facility or any tangible assets of a facility acquired on or after August 1, 1970, the excess of the price paid for such facility or such tangible assets over the historical cost, as defined in §413.134(b), or the cost basis, as determined under §413.134(g) (whichever is appropriate), is not includable in equity capital, and loans made to finance such excess portion of the cost of such acquisitions (see §413.153(d)) are excluded in computing equity capital.

(3) *Acquisitions prior to August 1970.* With respect to a facility or any tangible assets of a facility acquired before August 1970, the excess of the price paid for such facility or assets over the fair market value of tangible assets at the time of purchase is includable in equity capital to the extent that it is reasonable except that the cumulative allowable return for such excess may not exceed 100 percent of such excess. For purposes of this section, the cumulative allowable return means the sum of the allowable rate of return on equity capital for all months starting from August 1, 1970. For example, if the allowable rates of return on equity capital for a provider are 9 percent for the first year (and such year started August 1, 1970), 8.5 percent for the second year, and 10.5 percent for the third year, the cumulative allowable return at the end of the third year would be 28 percent. After the cumulative allowable return equals 100 percent, the inclusion in equity capital of the excess is no longer allowable.

(4) *Computation of return on equity capital.* For purposes of computing the allowable return, the amount of equity capital is the average investment during the reporting period. The rate of return allowed, as derived from time to time based upon interest rates in accordance with this principle, is determined by HCFA and communicated through intermediaries. Return on investment as an element of allowable costs is subject to apportionment in the same manner as other elements of allowable costs.

Example of calculation of cumulative allowable return. X purchased a provider on July 1, 1969, paying $100,000 in excess f the fair market value of the assets acquired. Provider X files its cost report on a calendar-year basis. The allowable rate of return on equity capital for August 1, 1970-December 31, 1970 (4.538 percent), is obtained by multiplying the allowable rate of return for the period ending December 31, 1970 (10.891) by 5/12 (a fraction of which the numerator is the number of months from August 1, 1970, to the end of the cost-reporting period and the denominator is the number of months in the cost-reporting period). The cumulative allowable return for Provider X for the period August 1, 1970-December 31, 1973, (32.367 percent) is computed as follows:

Cost reporting year ending	Rate of return on equity capital (percent)
Dec. 31, 1970	4.538
Dec. 31, 1971	8.969
Dec. 31, 1972	8.891
Dec. 31, 1973	9.969
Total	32.367

(The $100,000 paid in excess of the fair market value of the assets acquired is included in equity capital until the sum of the allowable rate of return on equity capital equals 100 percent. Of course, no portion of the $100,000 may be amortized as an allowable cost or is otherwise allowable for any program reimbursement purposes other than for determining the provider's equity capital.

[51 FR 34793, Sept. 30, 1986, as amended at 52 FR 21225, June 4, 1987; 52 FR 23398, June 19, 1987; 52 FR 32921, Sept. 1, 1987; 53 FR 12017, Apr. 12, 1988; 57 FR 39830, Sept. 1, 1992; 59 FR 26960, May 25, 1994]

Subpart H—Payment for End-Stage Renal Disease (ESRD) Services and Organ Procurement Costs

SOURCE: 62 FR 43668, Aug. 15, 1997, unless otherwise noted.

§413.170 Scope.

This subpart implements sections 1881 (b)(2) and (b)(7) of the Act by—

(a) Setting forth the principles and authorities under which HCFA is authorized to establish a prospective payment system for outpatient maintenance dialysis furnished in or under the supervision of an ESRD facility approved under subpart U of part 405 of this chapter (referred to as ''facility'' in this section). For purposes of this section and §413.172 through §413.198, ''outpatient maintenance dialysis'' means outpatient dialysis, home dialysis, self-dialysis, and home dialysis training, as defined in §405.2102 (f)(2)(ii), (f)(2)(iii), and (f)(3) of this chapter, and includes all items and services specified in §§410.50 and 410.52 of this chapter.

(b) Providing procedures and criteria under which a facility may receive an exception to the prospective payment rates; and

(c) Establishing procedures that a facility must follow to appeal its payment amount under the prospective payment system.

§413.172 Principles of prospective payment.

(a) Payments for outpatient maintenance dialysis are based on rates set prospectively by HCFA.

(b) All approved ESRD facilities must accept the prospective payment rates established by HCFA as payment in full for covered outpatient maintenance dialysis.

(c) HCFA publishes the methodology used to establish payment rates and the changes specified in §413.196(b) in the FEDERAL REGISTER.

§413.174 Prospective rates for hospital-based and independent ESRD facilities.

(a) *Establishment of rates.* HCFA establishes prospective payment rates for ESRD facilities using a methodology that—

(1) Differentiates between hospital-based facilities and independent ESRD facilities;

(2) Effectively encourages efficient delivery of dialysis services; and

(3) Provides incentives for increasing the use of home dialysis.

(b) *Determination of independent facility.* For purposes of rate-setting and payment under this section, HCFA considers any facility that does not meet all of the criteria of a hospital-based facility to be an independent facility. A determination under this paragraph (b) is an initial determination under §498.3 of this chapter.

(c) *Determination of hospital-based facility.* A determination under this paragraph (c) is an initial determination under §498.3 of this chapter. For purposes of rate-setting and payment under this section, HCFA determines that a facility is hospital-based if the—

(1) Facility and hospital are subject to the bylaws and operating decisions of a common governing board. This governing board, which has final administrative responsibility, approves all personnel actions, appoints medical staff, and carries out similar management functions;

(2) Facility's director or administrator is under the supervision of the hospital's chief executive officer and reports through him or her to the governing board;

(3) Facility personnel policies and practices conform to those of the hospital;

(4) Administrative functions of the facility (for example, records, billing, laundry, housekeeping, and purchasing) are integrated with those of the hospital; and

(5) Facility and hospital are financially integrated, as evidenced by the cost report, which reflects allocation of overhead to the facility through the required step-down methodology.

(d) *Nondetermination of hospital-based facility.* In determining whether a facility is hospital-based, HCFA does not consider—

(1) An agreement between a facility and a hospital concerning patient referral;

(2) A shared service arrangement between a facility and a hospital; or

(3) The physical location of a facility on the premises of a hospital.

(e) *Add-on amounts.* If all the physicians furnishing services to patients in an ESRD facility elect the initial method of payment (as described in § 414.313(c) of this chapter), the prospective rate (as described in paragraph (a) of this section) paid to that facility is increased by an add-on amount as described in § 414.313.

(f) *Erythropoietin/Epoietin (EPO).* (1) When EPO is furnished to an ESRD patient by a Medicare-approved ESRD facility or a supplier of home dialysis equipment and supplies, payment is based on the amount specified in paragraph (f)(3) of this section.

(2) The payment is made only on an assignment basis, that is, directly to the facility or supplier, which must accept, as payment in full, the amount that HCFA determines.

(3) HCFA determines the payment amount in accordance with the following rules:

(i) The amount is prospectively determined, as specified in section 1881(b)(11)(B)(ii) of the Act, reviewed and adjusted by HCFA, as necessary, and paid to hospital-based and independent dialysis facilities and to suppliers of home dialysis equipment and supplies, regardless of the location of the facility, supplier, or patient.

(ii) If HCFA determines that an adjustment to the payment amount is necessary, HCFA publishes a FEDERAL REGISTER notice proposing a revision to the EPO payment amount and requesting public comment.

(iii) Any increase in this amount for a year does not exceed the percentage increase (if any) in the implicit price deflator for gross national product (as published by the Department of Commerce) for the second quarter of the preceding year over the implicit price deflator for the second quarter of the second preceding year.

(iv) The Medicare payment amount is subject to the Part B deductible and coinsurance.

(g) *Additional payment for certain drugs.* In addition to the prospective payment described in this section, HCFA makes an additional payment for certain drugs furnished to ESRD patients by a Medicare-approved ESRD facility. HCFA makes this payment directly to the ESRD facility. The facility must accept the allowance determined by HCFA as payment in full. Payment for these drugs is made as follows:

(1) *Hospital-based facilities.* HCFA makes payments in accordance with the cost reimbursement rules set forth in this part.

(2) *Independent facilities.* HCFA makes payment in accordance with the methodology set forth in § 405.517 of this chapter for paying for drugs that are not paid on a cost or prospective payment basis.

§ 413.176 Amount of payments.

(a) If the beneficiary has incurred the full deductible applicable under Part B of Medicare before the dialysis treatment, the intermediary pays the facility 80 percent of its prospective payment rate.

(b) If the beneficiary has not incurred the full deductible applicable under Part B of Medicare before the dialysis treatment, the intermediary subtracts the amount applicable to the deductible from the facility's prospective rate and pays the facility 80 percent of the remainder, if any.

§ 413.178 Bad debts.

(a) HCFA will reimburse each facility its allowable Medicare bad debts, as defined in § 413.80(b), up to the facility's costs, as determined under Medicare principles, in a single lump sum payment at the end of the facility's cost reporting period.

(b) A facility must attempt to collect deductible and coinsurance amounts owed by beneficiaries before requesting reimbursement from HCFA for uncollectible amounts. Section 413.80 specifies the collection efforts facilities must make.

(c) A facility must request payment for uncollectible deductible and coinsurance amounts owed by beneficiaries by submitting an itemized list that specifically enumerates all uncollectable amounts related to covered services under the composite rate.

§ 413.180 Procedures for requesting exceptions to payment rates.

(a) *Outpatient maintenance dialysis payments.* All payments for outpatient maintenance dialysis furnished at or by facilities are made on the basis of prospective payment rates.

(b) *Criteria for requesting an exception.* If a facility projects on the basis of prior year costs and utilization trends that it will have an allowable cost per treatment higher than its prospective rate set under § 413.174, and if these excess costs are attributable to one or more of the factors in § 413.182, the facility may request, in accordance with paragraph (d) of this section, that HCFA approve an exception to that rate and set a higher prospective payment rate. However, a facility may only request an exception or seek to retain its previously approved exception rate when authorized under the conditions specified in paragraphs (d) and (e) of this section.

(c) *Application of deductible and coinsurance.* The higher payment rate is subject to the application of deductible and coinsurance in accordance with § 413.176.

(d) *Payment rate exception request.* A facility must request an exception to its payment rate within 180 days of—

(1) The effective date of its new composite payment rate(s);

(2) The effective date that HCFA opens the exceptions process; or

(3) The date on which an extraordinary cost-increasing event occurs, as specified (or provided for) in §§ 413.182(c) and 413.188.

(e) *Criteria for retaining a previously approved exception rate.* A facility may elect to retain its previously approved exception rate in lieu of any composite rate increase or any other exception amount if—

(1) The conditions under which the exception was granted have not changed;

(2) The facility files a request to retain the rate with its fiscal intermediary during the 30-day period before the opening of an exception cycle; and

(3) The request is approved by the fiscal intermediary.

(f) *Documentation for a payment rate exception request.* If the facility is requesting an exception to its payment rate, it must submit to HCFA its most recently completed cost report as required under § 413.198 and whatever statistics, data, and budgetary projections as determined by HCFA to be needed to adjudicate each type of exception. HCFA may audit any cost report or other information submitted. The materials submitted to HCFA must—

(1) Separately identify elements of cost contributing to costs per treatment in excess of the facility's payment rate;

(2) Show that the facility's costs, including those costs that are not directly attributable to the exception criteria, are allowable and reasonable under the reasonable cost principles set forth in this part;

(3) Show that the elements of excessive cost are specifically attributable to one or more conditions specified in § 413.182;

(4) Specify the amount of additional payment per treatment the facility believes is required for it to recover its justifiable excess costs; and

(5) Specify that the facility has compared its most recently completed cost report with cost reports from (at least 2) prior years. The facility must explain any material statistical data or cost changes, or both, and include an explanation with the documentation supporting the exception request.

(g) *Completion of requirements and criteria.* The facility must demonstrate to HCFA's satisfaction that the requirements of this section and the criteria in § 413.182 are fully met. The burden of proof is on the facility to show that one or more of the criteria are met and that the excessive costs are justifiable under the reasonable cost principles set forth in this part.

(h) *Approval of an exception request.* An exception request is deemed approved unless it is disapproved within 60 working days after it is filed with its intermediary.

(i) *Determination of an exception request.* In determining the facility's payment rate under the exception process, HCFA excludes all costs that are not reasonable or allowable under the reasonable cost principles set forth in this part.

(j) *Period of approval: Payment exception request.* Except for exceptions approved under §§ 413.180(e), 413.180(k), 413.182(c), and 413.188, a prospective exception payment rate approved by HCFA applies for the period from the date the complete exception request was filed with its intermediary until the earlier of the—

(1) Date the circumstances justifying the exception rate no longer exist; or

(2) End of the period during which the announced rate was to apply.

(k) *Period of approval: Payment exception request under §§ 413.182(c) and 413.188.* A prospective exception payment rate approved by HCFA under §§ 413.182(c) and 413.188 applies from the date of the extraordinary event until the end of the period during which the prospective announced rate was to apply, unless HCFA determines that another date is more appropriate. If HCFA does not extend the exception period and the facility believes that it continues to require an exception to its rate, the facility must reapply in accordance with the procedures in this section.

(l) *Denial of an exception request.* HCFA denies exception requests submitted without the documentation specified in § 413.182 and the applicable regulations cited there.

(m) *Criteria for refiling a denied exception request.* A facility that has been denied an exception request during the 180 days may file another exception request if all required documentation is filed with the intermediary by the 180th day.

§ 413.182 Criteria for approval of exception requests.

HCFA may approve exceptions to an ESRD facility's prospective payment rate if the facility demonstrates, by convincing objective evidence, that its total per treatment costs are reasonable and allowable under the relevant cost reimbursement principles of part 413 and that its per treatment costs in excess of its payment rate are directly attributable to any of the following criteria:

(a) Atypical service intensity (patient mix), as specified in § 413.184.

(b) Isolated essential facility, as specified in § 413.186.

(c) Extraordinary circumstances, as specified in § 413.188.

(d) Self-dialysis training costs, as specified in § 413.190.

(e) Frequency of dialysis, as specified in § 413.192.

§ 413.184 Payment exception: Atypical service intensity (patient mix).

(a) To qualify for an exception to the prospective payment rate based on atypical service intensity (patient mix)—

(1) A facility must demonstrate that a substantial proportion of the facility's outpatient maintenance dialysis treatments involve atypically intense dialysis services, special dialysis procedures, or supplies that are medically necessary to meet special medical needs of the facility's patients. Examples that may qualify under this criterion are more intense dialysis services that are medically necessary for patients such as—

(i) Patients who have been referred from other facilities on a temporary basis for more intense care during a period of medical instability and who return to the original facility after stabilization;

(ii) Pediatric patients who require a significantly higher staff-to-patient ratio than typical adult patients; or

(iii) Patients with medical conditions that are not commonly treated by ESRD facilities and that complicate the dialysis procedure.

(2) The facility must demonstrate clearly that these services, procedures, or supplies and its per treatment costs are prudent and reasonable when compared to those of facilities with a similar patient mix.

(3) A facility must demonstrate that—

(i) Its nursing personnel costs have been allocated properly between each mode of care; and

(ii) The additional nursing hours per treatment are not the result of an excess number of employees.

(b) *Documentation.* (1) A facility must submit a listing of all outpatient dialysis patients (including all home patients) treated during the most recently completed fiscal or calendar year showing—

(i) Patients who received transplants, including the date of transplant;

(ii) Patients awaiting a transplant who are medically able, have given consent, and are on an active transplant list, and projected transplants;

(iii) Home patients;

(iv) In-facility patients, staff-assisted, or self-dialysis;

(v) Individual patient diagnosis;

(vi) Diabetic patients;

(vii) Patients isolated because of contagious disease;

(viii) Age of patients;

(ix) Mortality rate, by age and diagnosis;

(x) Number of patient transfers, reasons for transfers, and any related information; and

(xi) Total number of hospital admissions for the facility's patients, reason for, and length of stay of each session.

(2) The facility also must—

(i) Submit documentation on costs of nursing personnel (registered nurses, licensed practical nurses, technicians, and aides) incurred during the most recently completed fiscal year cost report showing—

(A) Amount each employee was paid;

(B) Number of personnel;

(C) Amount of time spent in the dialysis unit; and

(D) Staff-to-patient ratio based on total hours, with an analysis of productive and nonproductive hours.

(ii) Submit documentation on supply costs incurred during the most recently completed fiscal or calendar year cost report showing—

(A) By modality, a complete list of supplies used routinely in a dialysis treatment;

(B) The make and model number of each dialyzer and its component cost; and

(C) That supplies are prudently purchased (for example, that bulk discounts are used when available).

(iii) Submit documentation on overhead costs incurred during the most recently completed fiscal or calendar year cost reporting year showing—

(A) The basis of the higher overhead costs;

(B) The impact on the specific cost components; and

(C) The effect on per treatment costs.

§ 413.186 Payment exception: Isolated essential facility.

(a) *Qualifications.* To qualify for an exception to the prospective payment rate based on being an isolated essential facility—

(1) The facility must be the only supplier of dialysis in its geographical area;

(2) The facility's patients must be unable to obtain dialysis services elsewhere without substantial additional hardship; and

(3) The facility's excess costs must be justifiable.

(b) *Criteria for determining qualifications.* In determining whether a facility qualifies for an exception based on its being an isolated essential facility, HCFA considers—

(1) Local, permanent residential population density;

(2) Typical local commuting distances from medical services;

(3) Volume of treatments; and

(4) The extent that other dialysis facilities are used by area residents (other than the applying facility's patients).

(c) *Documentation.* (1) *Isolated.* Generally, to be considered isolated, the facility must document that it is located outside an established Metropolitan Statistical Area and provides dialysis to a permanent patient population, as opposed to a transient patient population.

(2) *Essential.* To be considered essential, the facility must document—

(i) That a substantial number of its patients cannot obtain dialysis services elsewhere without additional hardship; and

(ii) The additional hardship the patients will incur in travel time and cost.

(3) *Cost per treatment.* The facility must—

(i) Document that its cost per treatment is reasonable; and

(ii) Explain how the facility's cost per treatment in excess of its composite rate relates to the isolated essential facility criteria specified in paragraph (b) of this section.

(4) *Additional information.* The facility must also furnish the following information in a format that concisely explains the facility's cost and patient data to support its request:

(i) A list of current and requested payment rates for each modality.

(ii) An explanation of how the facility's costs in excess of its composite rate payment are attributable to its being an isolated essential facility.

(iii) An explanation of any unusual geographic conditions in the area surrounding the facility.

(iv) A copy of the latest filed cost report and a budget estimate for the next 12 months prepared on cost report forms.

(v) An explanation of unusual costs reported on the facility's actual or budgeted cost reports and any significant changes in budgeted costs and data compared to actual costs and data reported on the latest filed cost report.

(vi) The name, location of, and distance to the nearest renal dialysis facility.

(vii) A list of patients by modality showing commuting distance and time to the current and the next nearest renal dialysis facility.

(viii) The historical and projected patient-to-staff ratios and number of machines used for maintenance dialysis treatments.

(ix) A computation showing the facility's treatment capacity, arrived at by taking the total stations multiplied by the number of hours of operation for the year divided by the average length of a dialysis treatment.

(x) The geographic boundaries and population size of the facility's service area.

§ 413.188 Payment exception: Extraordinary circumstances.

(a) To qualify for an exception to the prospective payment rate based on extraordinary circumstances, the facility must substantiate that it incurs excess costs beyond its control due to a fire, earthquake, flood, or other natural disaster.

(b) HCFA will not grant an exception based on increased costs if a facility has chosen not to—

(1) Maintain adequate insurance protection against such losses (through the purchase of insurance, the maintenance of a self-insurance program, or other equivalent alternative); or

(2) File a claim for losses covered by insurance or utilize its self-insurance program.

§ 413.190 Payment exception: Self-dialysis training costs.

(a) *Qualifications.* To qualify for an exception to the prospective payment rate based on self-dialysis training costs, the facility must establish that it incurs per treatment costs for furnishing self-dialysis and home dialysis training that exceed the facility's payment rate for such training sessions.

(b) *Justification.* To justify its exception request, a facility must—

(1) Separately identify those elements contributing to its costs in excess of the composite training rate; and

(2) Demonstrate that its per treatment costs are reasonable and allowable.

(c) *Criteria for determining proper cost reporting.* HCFA considers the facility's total costs, cost finding and apportionment, including its allocation of costs, to determine if costs are properly reported by treatment modality.

(d) *Limitation of exception requests.* Exception requests for a higher training rate are limited to those cost components relating to training such as technical staff, medical supplies, and the special costs of education (manuals and education materials). These requests may include overhead and other indirect costs to the extent that these costs are directly attributable to the additional training costs.

(e) *Documentation.* The facility must provide the following information to support its exception request:

(1) A copy of the facility's training program.

(2) Computation of the facility's cost per treatment for maintenance sessions and training sessions including an explanation of the cost difference between the two modalities.

(3) Class size and patients' training schedules.

(4) Number of training sessions required, by treatment modality, to train patients.

(5) Number of patients trained for the current year and the prior 2 years on a monthly basis.

(6) Projection for the next 12 months of future training candidates.

(7) The number and qualifications of staff at training sessions.

(f) *Accelerated training exception.* (1) An ESRD facility may bill Medicare for a dialysis training session only when a patient receives a dialysis treatment (normally three times a week for hemodialysis). Continuous cycling peritoneal dialysis (CCPD) and continuous ambulatory peritoneal dialysis (CAPD) are daily treatment modalities; ESRD facilities are paid the equivalent of three hemodialysis treatments for each week that CCPD and CAPD treatments are provided.

(2) If an ESRD facility elects to train all its patients using a particular treatment modality more often than during each dialysis treatment and, as a result, the number of billable training dialysis sessions is less than the number of actual training sessions, the facility may request a composite rate exception, limited to the lesser of the—

(i) Facility's projected training cost per treatment; or

(ii) Cost per treatment the facility would have received in training a patient if it had trained patients only during a dialysis treatment, that is, three times per week.

(3) An ESRD facility may bill a maximum of 25 training sessions per patient for hemodialysis training and 15 sessions for CCPD and CAPD training.

(4) In computing the payment amount under an accelerated training exception, HCFA uses a minimum number of training sessions per patient (15 for hemodialysis and 5 for CAPD and CCPD) when the facility actually provides fewer than the minimum number of training sessions.

(5) To justify an accelerated training exception request, an ESRD facility must document that a significant number of training sessions for a particular modality are provided during a shorter but more condensed period.

(6) The facility must submit with the exception request a list of patients, by modality, trained during the most recent cost report period. The list must include each beneficiary's—

(i) Name;

(ii) Age; and

(iii) Training status (completed, not completed, being retrained, or in the process of being trained).

(7) The total treatments from the patient list must be the same as the total treatments reported on the cost report filed with the request.

§ 413.192 Payment exception: Frequency of dialysis.

(a) *Qualification.* To qualify for an exception to the prospective payment rate based on frequency of dialysis, the facility must establish that it has a substantial portion of outpatient maintenance dialysis treatments furnished to patients who dialyze less frequently than three times per week.

(b) *Definition.* For purposes of this section, ''substantial'' means the number of treatments furnished by the facility is at least 15 percent lower than the number would be if all patients dialyzed three times a week.

(c) *Limitation for per treatment payment rates.* Per treatment payment rates granted under this exception may not exceed the amount that produces weekly payments per patient equal to three times the facility's prospective composite rate, exclusive of any exception amounts.

(d) *Documentation.* To document that an ESRD facility furnishes a substantial number of dialysis treatments at a frequency less than three times per week per patient, the facility must submit the following information:

(1) A list of patients receiving outpatient dialysis treatments for the cost report that is filed with the request. The list must indicate—

(i) Whether the patients are permanent, transient, or temporary;

(ii) The medically prescribed frequency of dialysis; and

(iii) The number of dialysis treatments that each patient received on a weekly and yearly basis and an explanation of any discrepancy between that calculation and the number of treatments reported on the facility's cost report.

(2) A list of patients used to project treatments. The list must indicate—

(i) Whether the patients are permanent, transient, or temporary;

(ii) The medically prescribed frequency of dialysis;

(iii) The number of dialysis treatments that each patient is projected to receive on a weekly and yearly basis, an explanation of any discrepancy between that calculation and the number of treatments reported on the facility's projected cost report, and an explanation for any change among prior, actual, and projected data.

(3) A schedule showing the number of treatments to be furnished twice a week and the number of treatments that would have been furnished if each patient were dialyzed three times a week.

(4) A computation of the facility's projected costs per treatment using the—

(i) Projected number of treatments furnished twice a week; and

(ii) Number of treatments if patients dialyze three times a week.

(5) A schedule showing the computation of the percentage decrease in the number of treatments.

§ 413.194 Appeals.

(a) *Appeals under section 1878 of the Act.* (1) A facility that disputes the amount of its allowable Medicare bad debts reimbursed by HCFA under § 413.178 may request review by the intermediary or the Provider Reimbursement Review Board (PRRB) in accordance with subpart R of part 405 of this chapter.

(2) A facility must request and obtain a final agency decision prior to seeking judicial review of a dispute regarding the amount of allowable Medicare bad debts.

(b) *Other appeals.* (1) A facility that has requested higher payment per treatment in accordance with § 413.180 may request review from the intermediary or the PRRB if HCFA has denied the request in whole or in part. In such a case, the procedure in subpart R of part 405 of this chapter is followed to the extent that it is applicable.

(2) The PRRB has the authority to review the action taken by HCFA on the facility's requests. However, the PRRB's decision is subject to review by the Administrator under § 405.1875 of this chapter.

(3) A facility must request and obtain a final agency decision, in accordance with paragraph (b)(1) of this section, prior to seeking judicial review of the denial, in whole or in part, of the exception request.

(c) *Procedure.* (1) The facility must request review within 180 days of the date of the decision on which review is sought.

(2) The facility may not submit to the reviewing entity, whether it is the intermediary or the PRRB, any additional information or cost data that had not been submitted to HCFA at the time HCFA evaluated the exception request.

(d) *Determining amount in controversy.* For purposes of determining PRRB jurisdiction under subpart R of part 405 of this chapter for the appeals described in paragraph (b) of this section—

(1) The amount in controversy per treatment is determined by subtracting the amount of program payment from the amount the facility requested under § 413.180; and

(2) The total amount in controversy is calculated by multiplying the amount in controversy per treatment by the projected number of treatments for the exception request period.

§ 413.196 Notification of changes in rate-setting methodologies and payment rates.

(a) HCFA or the facility's intermediary notifies each facility of changes in its payment rate. This notice includes changes in individual facility payment rates resulting from corrections or revisions of particular geographic labor cost adjustment factors.

(b) Changes in payment rates resulting from incorporation of updated cost data or general revisions of geographic labor cost adjustment factors are announced by notice published in the FEDERAL REGISTER without opportunity for prior comment. Revisions of the rate-setting methodology are published in the FEDERAL REGISTER in accordance with the Department's established rulemaking procedures.

§ 413.198 Recordkeeping and cost reporting requirements for outpatient maintenance dialysis.

(a) *Purpose and Scope.* This section implements section 1881(b)(2)(B)(i) of the Act by specifying recordkeeping and cost reporting requirements for ESRD facilities approved under subpart U of part 405 of this chapter. The records and reports will enable HCFA to determine the costs incurred in furnishing outpatient maintenance dialysis as defined in § 413.170(a).

(b) *Recordkeeping and reporting requirements.* (1) Each facility must keep adequate records and submit the appropriate HCFA-approved cost report in accordance with §§ 413.20 and 413.24, which provide rules on financial data and reports, and adequate cost data and cost finding, respectively.

(2) The cost reimbursement principles set forth in this part (beginning with § 413.134, Depreciation, and excluding the principles listed in paragraph (b)(4) of this section), apply in the determination and reporting of the allowable cost incurred in furnishing outpatient maintenance dialysis treatments to patients dialyzing in the facility, or incurred by the facility in furnishing home dialysis service, supplies, and equipment.

(3) Allowable cost is the reasonable cost related to dialysis treatments. Reasonable cost includes all necessary and proper expenses incurred by the facility in furnishing the dialysis treatments, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. It includes both direct and indirect costs and normal standby costs. Reasonable cost does not include costs that—

(i) Are not related to patient care for outpatient maintenance dialysis;

(ii) Are for services or items specifically not reimbursable under the program;

(iii) Flow from the provision of luxury items or servicess (items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services); or

(iv) Are found to be substantially out of line with other institutions in the same area that are similar in size, scope of services, utilization, and other relevant factors.

(4) The following principles of this part do not apply in determining adjustments to allowable costs as reported by ESRD facilities:

(i) Section 413.157, Return on equity capital of proprietary providers;

(ii) Section 413.200, Reimbursement of OPAs and histocompatibility laboratories;

(iii) Section 413.9, Cost related to patient care (except for the principles stated in paragraph (b)(3) of this section); and

(iv) Sections 413.64, Payments to providers, and §§ 413.13, 413.30, 413.35, 413.40, 413.74, and §§ 415.55 through 415.70, § 415.162, and § 415.164 of this chapter, Principles of reimbursement for services by hospital-based physicians.

§ 413.200 Payment of independent organ procurement organizations and histocompatibility laboratories.

(a) *Principle.* Covered services furnished after September 30, 1978 by organ procurement organizations (OPOs) and histocompatibility laboratories in connection with kidney acquisition and transplantation will be reimbursed under the principles for determining reasonable cost contained in this part. Services furnished by freestanding OPOs and histocompatibility laboratories, that have an agreement with the Secretary in accordance with paragraph (c) of this section, will be reimbursed by making an interim payment to the transplant hospitals using these services and by making a retroactive adjustment, directly with the OPO or laboratory, based upon a cost report filed by the OPO or laboratory. (The reasonable costs of services furnished by hospital based OPOs or laboratories will be reimbursed in accordance with the principles contained in §§ 413.60 and 413.64.)

(b) *Definitions.* For purposes of this section:

Freestanding refers to an OPO or a histocompatibility laboratory that is not—

(1) Subject to the control of the hospital with respect to the hiring, firing, training, and paying of employees; and

(2) Considered as a department of the hospital for insurance purposes (including malpractice insurance, general liability insurance, worker's compensation insurance, and employee retirement insurance).

Histocompatibility laboratory means a laboratory meeting the standards and providing the services for kidneys or other organs set forth in § 413.2171(d) of this chapter.

OPO means an organization defined in § 486.302 of this chapter.

(c) *Agreements with independent OPOs and laboratories.* (1) Any freestanding OPO or histocompatibility laboratory that wishes to have the cost of its pretransplant services reimbursed under the Medicare program must file an agreement with HCFA under which the OPO or laboratory agrees—

(i) To file a cost report in accordance with § 413.24(f) within three months after the end of each fiscal year;

(ii) To permit HCFA to designate an intermediary to determine the interim reimbursement rate payable to the transplant hospitals for services provided by the OPO or laboratory and to make a determination of reasonable cost based upon the cost report filed by the OPO or laboratory;

(iii) To provide such budget or cost projection information as may be required to establish an initial interim reimbursement rate;

(iv) To pay to HCFA amounts that have been paid by HCFA to transplant hospitals and that are determined to be in excess of the reasonable cost of the services provided by the OPO or laboratory; and

(v) Not to charge any individual for items or services for which that individual is entitled to have payment made under section 1861 of the Act.

(2) The initial cost report due from an OPO or laboratory is for its first fiscal year during any portion of which it had an agreement with the Secretary under paragraphs (c) (1) and (2) of this section. The initial cost report covers only the period covered by the agreement.

(d) *Interim reimbursement.* (1) Hospitals eligible to receive Medicare reimbursement for renal transplantation will be paid for the pretransplantation services of a freestanding OPO or histocompatibility laboratory that has an agreement with the Secretary under paragraph (c) of this section, on the basis of an interim rate established by an intermediary for that OPO or laboratory.

(2) The interim rate will be based on the average cost per service incurred by an OPO or laboratory, during its previous fiscal year, associated with procuring a kidney for transplantation. This interim rate may be adjusted if necessary for anticipated cost changes. If there is not adequate cost data to determine the initial interim rate, it will be determined according to the OPO's or laboratory's estimate of its projected costs for the fiscal year.

(3) Payments made on the basis of the interim rate will be reconciled directly with the OPO or laboratory after the close of its fiscal year, in accordance with paragraph (e) of this section.

(4) Information on the interim rate for all freestanding OPOs and histocompatibility laboratories shall be disseminated to all transplant hospitals and intermediaries.

(e) *Retroactive adjustment.* (1) *Cost reports.* Information provided in cost reports by freestanding OPOs and histocompatibility laboratories must meet the requirements for cost data and cost finding specified in paragraphs (a) through (e) of § 413.24. These cost reports must provide a complete accounting of the cost incurred by the agency or laboratory in providing covered services, the total number of Medicare beneficiaries who received those services, and any other data necessary to enable the intermediary to make a determination of the reasonable cost of covered services provided to Medicare beneficiaries.

(2) *Audit and adjustment.* A cost report submitted by a freestanding OPO or histocompatibility laboratory will be reviewed by the intermediary and a new interim reimbursement rate for the succeeding fiscal year will be established based upon this review. A retroactive adjustment in the amount paid under the interim rate will be made in accordance with § 413.64(f). If the determination of reasonable cost reveals an overpayment or underpayment resulting from the interim reimbursement rate paid to transplant

hospitals, a lump sum adjustment will be made directly between that intermediary and the OPO or laboratory.

(f) For services furnished on or after April 1, 1988, no payment may be made for services furnished by an OPO that does not meet the requirements of part 485, subpart D of this chapter.

(g) *Appeals.* Any OPO or histocompatibility laboratory that disagrees with an intermediary's cost determination under this section is entitled to an intermediary hearing, in accordance with the procedures contained in §§ 405.1811 through 405.1833, if the amount in controversy is $1,000 or more.

§ 413.202 Organ procurement organization (OPO) cost for kidneys sent to foreign countries or transplanted in patients other than Medicare beneficiaries.

An OPO's total costs for all kidneys is reduced by the costs associated with procuring kidneys sent to foreign transplant centers or transplanted in patients other than Medicare beneficiaries. OPOs, as defined in § 435.302 of this chapter, must separate costs for procuring kidneys that are sent to foreign transplant centers and kidneys transplanted in patients other than Medicare beneficiaries from Medicare allowable costs prior to final settlement by the Medicare fiscal intermediaries. Medicare costs are based on the ratio of the number of usable kidneys transplanted into Medicare beneficiaries to the total number of usable kidneys applied to reasonable costs. Certain long-standing arrangements that existed before March 3, 1988 (for example, an OPO that procures kidneys at a military transplant hospital for transplant at that hospital), will be deemed to be Medicare kidneys for cost reporting statistical purposes. The OPO must submit a request to the fiscal intermediary for review and approval of these arrangements.

§ 413.203 Transplant center costs for organs sent to foreign countries or transplanted in patients other than Medicare beneficiaries.

(a) A transplant center's total costs for all organs is reduced by the costs associated with procuring organs sent to foreign transplant centers or transplanted in patients other than Medicare beneficiaries. Organs are defined in § 486.302 (only covered organs will be paid for on a reasonable cost basis).

(b) Transplant center hospitals must separate costs for procuring organs that are sent to foreign transplant centers and organs transplanted in patients other than Medicare beneficiaries from Medicare allowable costs prior to final cost settlement by the Medicare fiscal intermediaries.

(c) Medicare costs are based on the ratio of the number of usable organs transplanted into Medicare beneficiaries to the total number of usable organs applied to reasonable costs.

Subpart I—Prospectively Determined Payment Rates for Low-Volume Skilled Nursing Facilities, for Cost Reporting Periods Beginning Prior to July 1, 1998

SOURCE: 60 FR 37594, July 21, 1995, unless otherwise noted.

§ 413.300 Basis and scope.

(a) *Basis.* This subpart implements section 1888(d) of the Act, which provides for optional prospectively determined payment rates for qualified SNFs.

(b) *Scope.* This subpart sets forth the eligibility criteria an SNF must meet to qualify, the process governing election of prospectively determined payment rates, and the basis and methodology for determining prospectively determined payment rates.

§ 413.302 Definitions.

For purposes of this subpart—

Area wage level means the average wage per hour for all classifications of employees as reported by health care facilities within a specified area.

Census region means one of the 9 census divisions, comprising the 50 States and the District of Columbia, established by the Bureau of the Census for statistical and reporting purposes.

Routine capital-related costs means the capital-related costs, allowable for Medicare purposes (as described in Subpart G of this Part), that are allocated

to the SNF participating inpatient routine service cost center as reported on the Medicare cost report.

Routine operating costs means the cost of regular room, dietary, and nursing services, and minor medical and surgical supplies for which a separate charge is not customarily made. It does not include the costs of ancillary services, capital-related costs, or, where appropriate, return on equity.

Rural area means any area outside an urban area in a census region.

Urban area means a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Office of Management and Budget, or a New England county deemed to be an urban area, as listed in §412.62(f)(1)(ii)(B) of this chapter.

§413.304 Eligibility for prospectively determined payment rates.

(a) *General rule.* An SNF is eligible to receive a prospectively determined payment rate for a cost reporting period if it had fewer than 1,500 Medicare covered inpatient days as reported on a Medicare cost report in its immediately preceding cost reporting period. This criterion applies even if the SNF received a prospectively determined payment rate during the preceding cost reporting period.

(b) *Less than a full cost reporting period.* If the cost reporting period that precedes an SNF's request for prospectively determined payment is not a full cost reporting period, the SNF is eligible to receive prospectively determined payment rates only if the average daily Medicare census for the period (Medicare inpatient days divided by the total number of days in the cost reporting period) is not greater than 4.1.

(c) *Newly-participating SNFs.* An SNF is eligible to receive prospectively determined payment rates for its first cost reporting period for which it is approved to participate in Medicare.

§413.308 Rules governing election of prospectively determined payment rates.

(a) *Requirements.* An SNF must notify its intermediary at least 30 calendar days before the beginning of the cost reporting period for which it requests to receive such payment that it elects prospectively determined payment rates. A separate request must be made for each cost reporting period for which an SNF seeks prospectively determined payment. A newly participating SNF with no preceding cost reporting period must make its election within 30 days of its notification of approval to participate in Medicare.

(b) *Intermediary notice.* After evaluating an SNF's request for prospectively determined payment rates, the intermediary notifies the SNF in writing as to whether the SNF meets any of the eligibility criteria described in §413.304 and the timely election requirements under §413.308(a). The intermediary must notify the SNF of its initial and final determinations within 10 working days after it receives all the data necessary to make each determination. The intermediary's determination is limited to one cost reporting period.

(c) *Prohibition against revocation.* An SNF may not revoke its request after it has received the initial determination of eligibility from the intermediary and the cost reporting period has begun.

(d) *Revocation by intermediary.* If an SNF is given tentative approval to receive a prospectively determined payment rate, and, after the start of the applicable cost reporting period, the intermediary determines that the SNF does not meet the eligibility criteria, the intermediary must revoke the prospectively determined payment option.

§413.310 Basis of payment.

(a) *Method of payment.* Under the prospectively determined payment rate system, a qualified SNF receives a per diem payment of a predetermined rate for inpatient services furnished to Medicare beneficiaries. Each SNF's routine per diem payment rate is determined according to the methodology described in §413.312 and is based on various components of SNF costs.

(b) *Payment in full.* The payment rate represents payment in full for routine services as described in §413.314 (subject to applicable coinsurance as described in Subpart G of Part 409 of this title), and for routine capital costs. Payment is made in lieu of payment on

a reasonable cost basis for routine services and for routine capital costs.

§ 413.312 Methodology for calculating rates.

(a) *Data used.* (1) To calculate the prospectively determined payment rates, HCFA uses:

(i) The SNF cost data that were used to develop the applicable routine service cost limits;

(ii) A wage index to adjust for area wage differences; and

(iii) The most recent projections of increases in the costs from the SNF market basket index.

(2) In the annual schedule of rates published in the FEDERAL REGISTER under the authority of § 413.320, HCFA announces the wage index and the annual percentage increases in the market basket used in the calculation of the rates.

(b) *Calculation of per diem rate.* (1) *Routine operating component of rate*—(i) *Adjusting cost report data.* The SNF market basket index is used to adjust the routine operating cost from the SNF cost report to reflect cost increases occurring between cost reporting periods represented in the data collected and the midpoint of the initial cost reporting period to which the payment rates apply.

(ii) *Calculating a per diem cost.* For each SNF, an adjusted routine operating per diem cost is computed by dividing the adjusted routine operating cost (see paragraph (b)(1)(i) of this section) by the SNF's total patient days.

(iii) *Adjusting for wage levels.* (A) The SNF's adjusted per diem routine operating cost calculated under paragraph (b)(1)(ii) of this section is then divided into labor-related and nonlabor-related portions.

(B) The labor-related portion is obtained by multiplying the SNF's adjusted per diem routine operating cost by a percentage that represents the labor-related portion of cost from the market basket. This percentage is published when the revised rates are published as described in § 413.320.

(C) The labor-related portion of each SNF's per diem cost is divided by the wage index applicable to the SNF's geographic location to arrive at the adjusted labor-related portion of routine cost.

(iv) *Group means.* SNFs are grouped by urban or rural location by census region. Separate means of adjusted labor-related and nonlabor routine operating costs for each SNF group are established in accordance with the SNF's region and urban or rural location. For each group, the mean labor-related and mean nonlabor-related per diem routine operating costs are multiplied by 105 percent.

(2) *Computation of routine capital-related cost.*

(i) The SNF routine capital-related cost for both direct and indirect capital costs allocated to routine services, as reported on the Medicare cost report, is obtained for each SNF in the data base.

(ii) For each SNF, the per diem capital-related cost is calculated by dividing the SNF's routine capital costs by its inpatient days.

(iii) SNFs are grouped by urban and rural location by census region, and mean per diem routine capital-related cost is determined for each group.

(iv) Each group mean per diem capital-related cost is multiplied by 105 percent.

(3) *Computation of return on owner's equity for services furnished before October 1, 1993.* (i) Each proprietary SNF's Medicare return on equity is obtained from its cost report and the portion attributable to the routine service cost is determined as described in § 413.157.

(ii) For each proprietary SNF, per diem return on equity is calculated by dividing the routine cost related return on equity determined under paragraph (b)(3)(i) of this section by the SNF's total Medicare inpatient days.

(iii) Separate group means are computed for per diem return on equity of proprietary SNFs, based on regional and urban or rural classification.

(iv) Each group mean is multiplied by 105 percent.

§ 413.314 Determining payment amounts: Routine per diem rate.

(a) *General rule.* An SNF that elects to be paid under the prospectively determined payment rate system, and qualifies for such payment, is paid a per diem rate for inpatient routine services. This rate is adjusted to reflect

area wage differences and the cost reporting period beginning date (if necessary) and is subject to the limitation specified in paragraph (d) of this section.

(b) *Per diem rate.* The prospectively determined payment rate for each urban and rural area in each census region is comprised of the following:

(1) A routine operating component, which is divided into:

(i) A labor-related portion adjusted by the appropriate wage index; and

(ii) A nonlabor-related portion.

(2) A routine capital-related cost portion.

(3) For proprietary SNFs only, a portion that is based on the return on owner's equity related to routine cost, applicable only for services furnished before October 1, 1993.

(c) *Adjustment for cost reporting period.* (1) If a facility has a cost reporting period beginning after the beginning of the Federal fiscal year, the intermediary increases the labor-related and nonlabor-related portions of the prospective payment rate that would otherwise apply to the SNF by an adjustment factor. Each factor represents the projected increase in the market basket index for a specific 12-month period. The factors are used to account for inflation in costs for cost reporting periods beginning after October 1. Adjustment factors are published in the annual notice of prospectively determined payment rates described in § 413.320.

(2) If a facility uses a cost reporting period that is not 12 months in duration, the intermediary must obtain a special adjustment factor from HCFA for the specific period.

(d) *Limitation of prospectively determined payment rate.* The per diem prospectively determined payment rate for an SNF, excluding capital-related costs and excluding return on equity for services furnished prior to October 1, 1993, may not exceed the individual SNF's routine service cost limit. Under § 413.30, the routine service cost limit is the limit determined without regard to exemptions, exceptions, or retroactive adjustments, and is the actual limit in effect when the provider elects to be paid a prospectively determined payment rate.

§ 413.316 Determining payment amounts: Ancillary services.

Ancillary services are paid on the basis of reasonable cost in accordance with section 1861(v)(1) of the Act and § 413.53.

§ 413.320 Publication of prospectively determined payment rates or amounts.

At least 90 days before the beginning of a Federal fiscal year to which revised prospectively determined payment rates are to be applied, HCFA publishes a notice in the FEDERAL REGISTER:

(a) Establishing the prospectively determined payment rates for routine services; and

(b) Explaining the basis on which the prospectively determined payment rates are calculated.

§ 413.321 Simplified cost report for SNFs.

SNFs electing to be paid under the prospectively determined payment rate system may file a simplified cost report. The cost report contains a simplified method of cost finding to be used in lieu of cost methods described in § 413.24(d). This method is specified in the instructions for Form HCFA–2540S, contained in sections 3000–3027.3 of Part 2 of the Provider Reimbursement Manual. This form may not be used by hospital-based SNFs or SNFs that are part of a health care complex. Those SNFs must file a cost report that reflects the shared services and administrative costs of the hospital and any other related facilities in the health care complex.

Subpart J—Prospective Payment for Skilled Nursing Facilities

SOURCE: 63 FR 26309, May 12, 1998, unless otherwise noted.

§ 413.330 Basis and scope.

(a) *Basis.* This subpart implements section 1888(e) of the Act, which provides for the implementation of a prospective payment system for SNFs for cost reporting periods beginning on or after July 1, 1998.

(b) *Scope.* This subpart sets forth the framework for the prospective payment system for SNFs, including the methodology used for the development of payment rates and associated adjustments, the application of a transition phase, and related rules.

§ 413.333 Definitions.

As used in this subpart—

Case-mix index means a scale that measures the relative difference in resource intensity among different groups in the resident classification system.

Market basket index means an index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered skilled nursing services.

Resident classification system means a system for classifying SNF residents into mutually exclusive groups based on clinical, functional, and resource-based criteria. For purposes of this subpart, this term refers to the current version of the Resource Utilization Groups, as set forth in the annual publication of Federal prospective payment rates described in § 413.345.

Rural area means any area outside of an urban area.

Urban area means a metropolitan statistical area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Office of Management and Budget, or a New England county deemed to be an urban area, as listed in § 412.62(f)(1)(ii)(B) of this chapter.

[63 FR 26309, May 12, 1998; 63 FR 53307, Oct. 5, 1998]

§ 413.335 Basis of payment.

(a) *Method of payment.* Under the prospective payment system, SNFs receive a per diem payment of a predetermined rate for inpatient services furnished to Medicare beneficiaries. The per diem payments are made on the basis of the Federal payment rate described in § 413.337 and, during a transition period, on the basis of a blend of the Federal rate and the facility-specific rate described in § 413.340. These per diem payment rates are determined according to the methodology described in § 413.337 and § 413.340.

(b) *Payment in full.* The payment rates represent payment in full (subject to applicable coinsurance as described in subpart G of part 409 of this chapter) for all costs (routine, ancillary, and capital-related) associated with furnishing inpatient SNF services to Medicare beneficiaries other than costs associated with operating approved educational activities as described in § 413.85.

§ 413.337 Methodology for calculating the prospective payment rates.

(a) *Data used.* (1) To calculate the prospective payment rates, HCFA uses—

(i) Medicare data on allowable costs from freestanding and hospital-based SNFs for cost reporting periods beginning in fiscal year 1995. SNFs that received ''new provider'' exemptions under § 413.30(e)(2) are excluded from the data base used to compute the Federal payment rates. In addition, allowable costs related to exceptions payments under § 413.30(f) are excluded from the data base used to compute the Federal payment rates;

(ii) An appropriate wage index to adjust for area wage differences;

(iii) The most recent projections of increases in the costs from the SNF market basket index;

(iv) Resident assessment and other data that account for the relative resource utilization of different resident types; and

(v) Medicare Part B SNF claims data reflecting amounts payable under Part B for covered SNF services (other than those services described in § 411.15(p)(2) of this chapter) furnished during SNF cost reporting periods beginning in fiscal year 1995 to individuals who were residents of SNFs and receiving Part A covered services.

(b) *Methodology for calculating the per diem Federal payment rates*—(1) *Determining SNF costs.* In calculating the initial unadjusted Federal rates applicable for services provided during the period beginning July 1, 1998 through September 30, 1999, HCFA determines each SNF's costs by summing its allowable costs for the cost reporting period beginning in fiscal year 1995 and its estimate of Part B payments (described in paragraphs (a)(1)(i) and (a)(1)(v) of this section).

(2) *Use of market basket index.* The SNF market basket index is used to adjust the SNF cost data to reflect cost increases occurring between cost reporting periods represented in the data and the initial period (beginning July 1, 1998 and ending September 30, 1999) to which the payment rates apply. For each year, the cost data are updated by a factor equivalent to the annual market basket index percentage minus 1 percentage point.

(3) *Calculation of the per diem cost.* For each SNF, the per diem cost is computed by dividing the cost data for each SNF by the corresponding number of Medicare days.

(4) *Standardization of data for variation in area wage levels and case-mix.* The cost data described in paragraph (b)(2) of this section are standardized to remove the effects of geographic variation in wage levels and facility variation in case-mix. The cost data are standardized for geographic variation in wage levels using the wage index. The cost data are standardized for facility variation in case-mix using the case-mix indices and other data that indicate facility case-mix.

(5) *Calculation of unadjusted Federal payment rates.* HCFA calculates the national per diem unadjusted payment rates by urban and rural classification in the following manner:

(i) By computing the average per diem standardized cost of freestanding SNFs weighted by Medicare days.

(ii) By computing the average per diem standardized cost of freestanding and hospital-based SNFs combined weighted by Medicare days.

(iii) By computing the average of the amounts determined under paragraphs (b)(5)(i) and (b)(5)(ii) of this section.

(c) *Calculation of adjusted Federal payment rates for case-mix and area wage levels.* The Federal rate is adjusted to account for facility case-mix using a resident classification system and associated case-mix indices that account for the relative resource utilization of different patient types. This classification system utilizes the resident assessment instrument completed by SNFs as described at § 483.20 of this chapter, according to the assessment schedule described in § 413.343(b). The Federal rate is also adjusted to account for geographic differences in area wage levels using an appropriate wage index.

(d) *Annual updates of Federal unadjusted payment rates.* HCFA updates the unadjusted Federal payment rates on a fiscal year basis.

(1) For fiscal years 2000 through 2002, the unadjusted Federal rate is equal to the rate for the previous period or fiscal year increased by a factor equal to the SNF market basket index percentage minus 1 percentage point.

(2) For subsequent fiscal years, the unadjusted Federal rate is equal to the rate for the previous fiscal year increased by the applicable SNF market basket index amount.

§ 413.340 Transition period.

(a) *Duration of transition period and proportions for the blended transition rate.* Beginning with an SNF's first cost reporting period beginning on or after July 1, 1998, there is a transition period covering three cost reporting periods. During this transition phase, SNFs receive a payment rate comprising a blend of the adjusted Federal rate and a facility-specific rate. For the first cost reporting period beginning on or after July 1, 1998, payment is based on 75 percent of the facility-specific rate and 25 percent of the Federal rate. For the subsequent cost reporting period, the rate is comprised of 50 percent of the facility-specific rate and 50 percent of the Federal rate. In the final cost reporting period of the transition, the rate is comprised of 25 percent of the facility-specific rate and 75 percent of the Federal rate. For all subsequent cost reporting periods, payment is based entirely on the Federal rate.

(b) *Calculation of facility-specific rate for the first cost reporting period.* The facility-specific rate is computed based on the SNF's Medicare allowable costs from its fiscal year 1995 cost report plus an estimate of the amounts payable under Part B for covered SNF services (other than those services described in § 411.15(p)(2) of this chapter) furnished during fiscal year 1995 to individuals who were residents of SNFs and receiving Part A covered services.

Allowable costs associated with exceptions, as described in § 413.30(f), are included in the calculation of the facility-specific rate. Allowable costs associated with exemptions, as described in § 413.30(e)(2), are included in the calculation of the facility-specific rate but only to the extent that they do not exceed 150 percent of the routine cost limit. Low Medicare volume SNFs that were paid a prospectively determined rate under § 413.300 for their cost reporting period beginning in fiscal year 1995 will utilize that rate as the basis for the allowable costs of routine (operating and capital-related) expenses in determining the facility-specific rate. Each SNF's allowable costs are updated to the first cost reporting period to which the payment rates apply using annual factors equal to the SNF market basket percentage minus 1 percentage point.

(c) *SNFs participating in the Multistate Nursing Home Case-Mix and Quality Demonstration.* SNFs that participated in the Multistate Nursing Home Case-Mix and Quality Demonstration in a cost reporting period that began in calendar year 1997 will utilize their allowable costs from that cost reporting period, including prospective payment amounts determined under the demonstration payment methodology.

(d) *Update of facility-specific rates for subsequent cost reporting periods.* The facility-specific rate for a cost reporting period that is subsequent to the first cost reporting period is equal to the facility-specific rate for the first cost reporting period (described in paragraph (a) of this section) updated by the market basket index.

(1) For a subsequent cost reporting period beginning in fiscal years 1998 and 1999, the facility-specific rate is equal to the facility-specific rate for the previous cost reporting period updated by the applicable market basket index percentage minus one percentage point.

(2) For a subsequent cost reporting period beginning in fiscal year 2000, the facility-specific rate is equal to the facility-specific rate for the previous cost reporting period updated by the applicable market basket index percentage.

(e) *SNFs excluded from the transition period.* SNFs that received their first payment from Medicare, under present or previous ownership, on or after October 1, 1995, are excluded from the transition period, and payment is made according to the Federal rates only.

§ 413.343 Resident assessment data.

(a) *Submission of resident assessment data.* SNFs are required to submit the resident assessment data described at § 483.20 of this chapter in the manner necessary to administer the payment rate methodology described in § 413.337. This provision includes the frequency, scope, and number of assessments required.

(b) *Assessment schedule.* In accordance with the methodology described in § 413.337(c) related to the adjustment of the Federal rates for case-mix, SNFs must submit assessments according to an assessment schedule. This schedule must include performance of patient assessments on the 5th, 14th, 30th, 60th, and 90th days of posthospital SNF care and such other assessments that are necessary to account for changes in patient care needs.

(c) *Noncompliance with assessment schedule.* HCFA pays a default rate for the Federal rate when a SNF fails to comply with the assessment schedule in paragraph (b) of this section. The default rate is paid for the days of a patient's care for which the SNF is not in compliance with the assessment schedule.

[63 FR 26309, May 12, 1998, as amended at 64 FR 41682, July 30, 1999]

§ 413.345 Publication of Federal prospective payment rates.

HCFA publishes information pertaining to each update of the Federal payment rates in the FEDERAL REGISTER. This information includes the tandardized Federal rates, the resident classification system that provides the basis for case-mix adjustment (including the designation of those specific Resource Utilization Groups under the resident classification system that represent the required SNF level of care, as provided in § 409.30 of this chapter), and the wage index. This information is published before May 1 for the fiscal

year 1998 and before August 1 for the fiscal years 1999 and after.

§ 413.348 Limitation on review.

Judicial or administrative review under sections 1869 or 1878 of the Act or otherwise is prohibited with regard to the establishment of the Federal rates. This prohibition includes the methodology used in the computation of the Federal standardized payment rates, the case-mix methodology, and the development and application of the wage index. This prohibition on judicial and administrative review also extends to the methodology used to establish the facility-specific rates but not to determinations related to reasonable cost in the fiscal year 1995 cost reporting period used as the basis for these rates.

§ 413.350 Periodic interim payments for skilled nursing facilities receiving payment under the skilled nursing facility prospective payment system for Part A services.

(a) *General rule.* Subject to the exceptions in paragraphs (b) and (c) of this section, SNFs receiving payment under the PPS for Part A services do not receive interim payments during the cost reporting year, and receive payment only following submission of a bill. Paragraph (d) of this section provides for accelerated payments in certain circumstances.

(b) *Periodic interim payments.* (1) An SNF receiving payment under the prospective payment system may receive periodic interim payments (PIP) for Part A SNF services under the PIP method subject to the provisions of § 413.64(h). To be approved for PIP, the SNF must meet the qualifying requirements in § 413.64(h)(3). Moreover, as provided in § 413.64(h)(5), intermediary approval is conditioned upon the intermediary's best judgment as to whether payment can be made under the PIP method without undue risk of its resulting in an overpayment to the provider.

(2) *Frequency of payment.* The intermediary estimates an SNF's prospective payments net of estimated beneficiary coinsurance and makes biweekly payments equal to 1/26 of the total estimated amount of payment for the year. If an SNF has payment experience under the prospective payment system, the intermediary estimates PIP based on that payment experience, adjusted for projected changes supported by substantiated information for the current year. Each payment is made 2 weeks after the end of a biweekly period of service as described in § 413.64(h)(6). The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an SNF receives interim payments for less than a full reporting period. These payments are subject to final settlement.

(3) *Termination of PIP*—(i) *Request by the SNF.* An SNF receiving PIP may convert to receiving prospective payments on a non-PIP basis at any time.

(ii) *Removal by the intermediary.* An intermediary terminates PIP if the SNF no longer meets the requirements of § 413.64(h).

(c) *Interim payments for Medicare bad debts and for Part A costs not paid under the prospective payment system.* For Medicare bad debts and for costs of an approved education program and other costs paid outside the prospective payment system, the intermediary determines the interim payments by estimating the reimbursable amount for the year based on the previous year's experience, adjusted for projected changes supported by substantiated information for the current year, and makes biweekly payments equal to 1/26 of the total estimated amount. Each payment is made 2 weeks after the end of a biweekly period of service as described in § 413.64(h)(6). The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an SNF receives interim payments for less than a full reporting period. These payments are subject to final cost settlement.

(d) *Accelerated payments*—(1) *General rule.* Upon request, an accelerated payment may be made to an SNF that is receiving payment under the prospective payment system and is not receiving PIP under paragraph (b) of this section if the SNF is experiencing financial difficulties because of the following:

(i) There is a delay by the intermediary in making payment to the SNF.

(ii) Due to an exceptional situation, there is a temporary delay in the SNF's preparation and submittal of bills to the intermediary beyond its normal billing cycle.

(2) *Approval of payment.* An SNF's request for an accelerated payment must be approved by the intermediary and HCFA.

(3) *Amount of payment.* The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(4) *Recovery of payment.* Recovery of the accelerated payment is made by recoupment as SNF bills are processed or by direct payment by the SNF.

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PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

Subpart A—General Provisions

Subpart B—Physicians and Other Practitioners

Subpart C [Reserved]

Subpart D—Payment for Durable Medical Equipment and Prosthetic and Orthotic Devices

Subpart E—Determination of Reasonable Charges Under the ESRD Program

Subparts F–H—[Reserved]